The Lunatic Asylum in British India, 1857 to 1880: colonialism, medicine and power.

JAMES H. MILLS

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I confirm that this thesis
is entirely my own work
and has been composed by myself.

James H. Mills.

ABSTRACT.

The thesis explores three issues at the asylum in British India which are central to discussions of colonial and medical power.

The first focuses on the asylum as a site for the production of colonial knowledge. The methodological problems of using documents are a current concern in both medical and colonial history and two chapters explore the themes common to both disciplines by looking at medical documents and medical data produced in a colonial context.

Chapter 1 investigates the psychological case note as a source for the historian and demonstrates that although the nature of the information contained there makes problematic the common project of statistical profiling of patient populations, discourse analysis as a methodology can render such documents a fruitful source for exploring power relations in the colonial and medical institution.

Chapter 2 focuses on the information systems of colonial government by interpreting the asylum as a laboratory in the colonial government for observing the Indian population and gathering information about it. In this chapter the techniques of looking at the Indian's body and behaviour through medical science are traced and the ways that the knowledge produced through these techniques became implicated in the wider concerns of colonial government to create public order issues is explored by using the case study of the cannabis user as a focus of British anxiety.

The second aspect of the asylum is a focus on the asylum as a site for colonial strategies of control and discipline. Chapter 3 examines the British admissions policy in the context of colonial policing requirements and relates the incarceration policy to the priority accorded to controlling mobile populations in India rather than to a genuine concern for the fate of the mentally disordered.

Chapter 4 concentrates on the treatment regime inside the asylum where the Indian patient was expected to submit to the authority of the medical officer and become reformed into an ordered and productive individual.

The third aspect of the asylum stands as a balance to these discourse/discipline themes as it focuses on Indian agents in the asylum system. Chapter 5 looks at the interaction of the local community with the asylum and asserts that their use of it was associated with their own agendas rather than those of the colonial government which provided the institution. Chapter 6 explores the way that the patients and indeed the Indian attendants and doctors shaped the asylum experience and shows how the colonial project was frequently frustrated, negotiated and ignored.

A low priority medical institution like the asylum is an important site for understanding the colonial encounter. While it is possible to trace the functioning of colonial power at the asylum through the knowledge it produced and the agendas it pursued, the day-to-day experiences at the institutions in British India provide examples of the power(s) that were operating in even that most colonial of situations, the carceral institution. Evidence of such power(s) is an important reminder that the colonial context is only ever one of a range of ways in which the actions of those in British India might be understood.

This thesis aims to contribute both to the history of colonialism and discussions of the history of psychological medicine.

CONTENTS.

FIGURES/ TABLES.

Figures.

Tables.

ABBREVIATIONS.

Ben.	Bengal.
Bom.	Bombay.
Civ. Asst. Surg.	Civil Assistant Surgeon.
Civ. Surg.	Civil Surgeon.
C. Provs.	Central Provinces.
Comm.	Commissioner.
GOI	Government of India.
IESHR	Indian Economic and Social History Review.
IGH	Inspector-General of Hospitals.
IGP	Inspector-General of Prisons.
I.G. Police	Inspector-General of Police.
IMD	Indian Medical Department.
LA	Lunatic Asylum.
Mad.	Madras.
Mag.	Magistrate.
NWP	North-Western Provinces.
Pres.	President.
Sec.	Secretary.
Super.	Superintendent.

NOTE.

volume number.	**patient number in volume.**	**date of admission.**
Case Book IA,	patient no. 1,	admitted 1 January 1861.

The above is an example of the references in the footnotes made to the case notes of the Lucknow Lunatic Asylum (see Preface and Bibliography for details). The reference is to which of the volumes contains the case note (the original numbering on the three surviving volumes is IA, II and IV and this has been retained), to the patient number within that volume and the date on which that patient was admitted according to the information available on the case note.

PREFACE.

This thesis owes a special debt to Dr. Crispin Bates of the Department of History, Edinburgh University. Always available, he has been a constant source of all those qualities that a Ph. D. candidate most lacks, from common sense to intellectual insight. I thank him for all the effort he has put into helping me.

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INTRODUCTION.

INTRODUCTION.

From a very early date there is evidence that the British decided that a specialist facility needed to be available to them in which they could segregate those they encountered in the Indian population as insane. In 1795 the Commander in Chief of the Bengal Army wrote to the Governor General proposing to establish a 'house' at Monghier in which mad sepoys could be incarcerated.[1] At the time there were three such soldiers locked up in the guard room at the invalid depot in that garrison, a state of affairs the Commander considered highly unsuitable. The Governor-General's response was very positive as he agreed that this was all a good idea and sanctioned a facility to be designed for the reception of about twenty patients which could be expanded further should there be the demand.[2]

Just over eighty-five years later it was announced that, "the asylum at Hazaribagh was closed in the month of March".[3] Coming soon after the decision to put the Moydapore institution into mothballs,[4] the expansion of the asylum system for those the British considered mad and wished to incarcerate amongst the Indian population effectively ended and a period followed when new asylums were no longer planned and the numbers of those detained levelled off in the institutions which did remain. It is the twenty three years immediately preceding the publication in 1880 of the decision to close the Hazaribagh asylum which will be examined here.

The reason that the period 1857 to 1880 is the chronological focus is not simply that it was the first years of direct rule of India by the British after the dissolution of the East India Company. The period was the most significant in the history of asylum provision for Indians by the British in the nineteenth century.

For example, in the realm of law it was a period of important activity. Act XXXVI of 1858 was the first act specifically designed to provide a legal framework for incarcerating those Indians considered mad by the British who had not come to the attention of the authorities through criminal behaviour.[5] The legal provisions for criminal lunatics of the various administrations of India were also standardised in Chapter XXVII of the Criminal Procedure Code which was passed in 1861.

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[1]Chief Commissioner to Gvt.Bengal in Bengal (Military) 3 April 1795.
[2]Letters received from Bengal 14 May 1795, para.27.
[3]*Annual Report on the Insane Asylums in Bengal for the Year 1879*, p1.
[4]*Asylums in Bengal for the Year 1877*, p29.
[5]See Appendix I.

While the British in this period were establishing a legal framework in which those Indians they considered mad could be dealt with, they were also setting up an institutional network in which those Indians could be detained. With the opening of the Lucknow Lunatic Asylum in 1859 there began two decades of unprecedented activity in providing buildings to contain those the British encountered as 'mad' in the Indian population. Of the twenty-six asylums which operated in the areas under the jurisdiction of the Government of India in this period no less than sixteen have their origins in the 1860s and 1870s.[6] Alongside this building of new asylums the institutions which pre-dated the period 1857-1880 were the subject of expansion programmes, so that reports such as that for the Dacca Asylum in 1875 were common:

> The Construction of cells has been sanctioned by His Honor the Lieutenant Governor, and will be carried out at a cost not exceeding Rs.21500 ... This new building will consist of 20 cells capable of accommodating 40 lunatics, two in each cell, on the plan of the present female ward.[7]

This host of new buildings was quickly pressed into use and it was in this period that the number of detainees in institutions designated 'lunatic asylums' made the most significant leaps of the nineteenth century. Just looking at the asylum population figures of the three Presidencies demonstrates the importance of the period. In 1865 in the asylums of the Bombay Presidency there were 353[8] inmates at the end of the year, by 1875 there were 568[9] and by 1880 646.[10] The asylum population grew by some 83% in the fifteen year period until 1880, leaping 60% in the decade between 1865 and 1875 alone. In the fifteen years after 1880 though the asylum population grew by just 10%.[11] In Madras the population of the asylum was just 140[12] people in 1867, but by 1880 this had more than doubled to 330.[13] This remarkable period of growth continued until 1885 when the asylum population reached 600[14] people at which point it seems to have virtually stopped growing, peaking in the nineteenth century at 608[15] in 1895 before falling to 559[16] in 1900.

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[6]See Appendix II.
[7]*Asylums in Bengal for the Year 1875*, p17.
[8]*Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1874-5*, pp30-33.
[9]Ibid.
[10]*Asylums in the Bombay Presidency for the Year 1880*, p8.
[11]*Asylums in the Bombay Presidency for the Year 1900*, p8.
[12]*Annual Report of the Three Lunatic Asylums in the Madras Presidency during the Year 1877-8*, p33.
[13]*Asylums in the Madras Presidency during the Year 1879-80*, p29.
[14]*Asylums in the Madras Presidency during the Year 1890*, p10.
[15]*Asylums in the Madras Presidency during the Year 1900*, p20.
[16]Ibid.

It was in the Bengal Presidency, which had the most asylums of any one administration in India and in which the most people were incarcerated as 'lunatics' that the story of this period is most clearly told. In 1865 the total population of all the asylums was 627 people which by 1875 had risen to 1147,[17] a growth of 82% in ten years. This was a peak in the nineteenth century as ten years later the population was 955[18] and by 1900 the population had fallen to 906.[19]

As is evident from such figures this was hardly the 'great incarceration' of people in which the asylum has been implicated in the nineteenth century European context. Figures available for 1880 suggest that there were only around 2750 patients incarcerated for the whole of India at the end of a period of rapid expansion and after which rates of growth in the asylum population slowed to a trickle or even turned negative.[20] What is being explored here then is not a series of institutions which contained a significant proportion of the Indian population. It is the burst of energy in the provision of facilities for those that the British decided were 'lunatic' in the two decades or so after they took direct control of the government of India in 1857 that will need explaining and which promises to bring into focus the concerns and contemplated projects of the British in India in such an important period.

The Asylums and Knowledge: colonial and medical discourse.

There is a wide range of sources available through which the asylums of the period 1857-1880 can be explored and examined. The various individual asylums began to produce end of year reports in this period in which the comments of the superintendent would precede statistical summaries of the year's events, recording the numbers of people admitted according to such indicators as age, caste and gender as well as the numbers of those thought to have been admitted suffering from each type of illness diagnosed, the number of inmates who had died, the causes of death etc. (see Figure I for an indication of the types of information being collected and tabulated).[21]

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[17] *Annual Report of the Insane Asylums in Bengal for the Year 1875*, p28.
[18] *Asylums in Bengal for the Year 1890*, p2.
[19] *Asylums in Bengal for the Year 1900*, p2.
[20] This does not include the Lucknow Asylum and the three Asylums in the North-Western Provinces for which figures are not available.
[21] Index to *Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1873.*

INDEX.

Figure I. Index to *Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1873.*

There is also an extensive set of case notes available from the Lucknow Lunatic Asylum for the period 1859 to 1872. For each person admitted to the institution in this period there is an individual paper on which the British medical officer in charge of the asylum recorded information about that person, such as name, age and caste. This document also contained a series of observations about the behaviour and health of the person.

Apart from these routine administrative records there is all manner of incidental material available, mentions of asylums in the Proceedings of the various departments of the Government of India, lengthy reports in response to Government enquiries and articles in the professional journals of the day. Yet it is not at all clear what use should be made of this wealth of materials. The most recent studies of asylums in Europe have been inclined to accept that the statistics and observations generated in the lunatic asylums of the nineteenth century are decent enough representations of the reality of the period and have engaged in the process of piecing together the information so as to create a picture of the goings-on in certain institutions.[22] This is not the approach to be taken here as the development of a number of theoretical objections to the idea that such documents can ever constitute a faithful depiction of the reality of a period means that alternative approaches to the sources need to be considered.

These theoretical objections spring from the observation that the modern understanding of the relationship between reality and language as "a perpetual and objectively based correlation of the visible and the expressible"[23] is not natural but historical. As Hayden White points out:

> The illusion on which all of the modern human sciences have been founded is that words enjoy a privileged status among the order of things as transparent icons, as value-neutral instruments of representation. The ascription to words of such an ontologically privileged status among the order of things is a mistake which modern linguistic theory at last has permitted to be identified. What modern linguistic theory demonstrates is that words are merely things among other things in the world, and that they will always obscure as much as they reveal about the objects they are meant to signify.[24]

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[22]A.Beveridge, 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston 1873-1908' Part I in *History of Psychiatry* vi (1995), pp21-54; Part II in *History of Psychiatry* vi (1995), pp431-451; H.Deacon, *A History of the Medical Institutions on Robben Island, Cape Colony 1846-1910*, (Ph.D. thesis Cambridge 1994).

[23]M.Foucault, *The Birth of the Clinic: An archaeology of medical perception*, (Tavistock London 1973), p196.

[24]H.White, *Tropics of Discourse: essays in cultural criticism*, (John Hopkins University Press 1978), p232.

If words are not the 'value-neutral instruments of representation' that it has been assumed that they were, then the power relations behind the choice of certain words to form certain knowledges of people and places are what any study of those words will reveal, rather than 'truthful' or accurate pictures of those people and places.

In the colonial context this has lead to the study of colonial discourses or, put simply, how knowledge was related to power relations in the colonial encounter. The answer reached is that suggested by Edward Said: "We would not have had empire itself without important philosophical and imaginative processes at work".[25]

This means that the knowledge of the non-Western world contained in the extensive body of writings by the scholars, travellers and administrators of the West is no simple reproduction of an actual reality which exists outside of that literature and which is faithfully recounted there. Rather it is a production of the minds and imaginations of the West. The categories by which the non-Western world comes to be known are inventions of the West, of the "'communities of interpretation' which gave them existence ... each designation represented interests, claims, projects and rhetorics".[26] These categories by which the non-West came to be produced in the imagination of the West were negatives of the West; irrational, mystical, weak, ill.

This invention of the non-West by the West was no harmless exercise in whimsy. Dagmar Engels emphasises this:

> Knowledge as a 'discursive practice' implied the right to specify subjects of debate, and the space in which they were articulated as well as the right to coordinate, subordinate and appropriate statements and concepts. Within this context British administrators and politicians in India justified their supremacy, set up their administration, codified the law and established an educational system.[27]

Tejaswini Niranjana also points out that "the practices of subjection/subjectification implicit in the colonial enterprise operate not merely through the coercive machinery of the state, but also through the discourses of philosophy, history, anthropology, philology, linguistics, and literary interpretation".[28] A moral universe was created in

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[25]E.Said, 'Representing the colonized: anthropology's interlocutors', in *Critical Inquiry* 15 (1989), p216.
[26]E.Said, 'Orientalism Reconsidered', in Francis Barker et al.(eds.), *Literature, Politics and Theory* (London 1986), p214.
[27]D.Engels, 'Modes of knowledge, modes of power: universities in 19th-century India', in D.Engels and S.Marks, *Contesting Colonial Hegemony* (British Academic Press London 1994), p87.
[28]T.Niranjana, *Siting Translation: history, post-structuralism, and the colonial context*, (University of California Press 1992), p1.

the written texts of the West where it became strong and superior, the non-West backward and dark. This was the moral universe in which the figure of the Westerner as coloniser can be understood.

Texts from the colonial period must therefore be read not as true representations of some actual situation at the time but as instances where ideas and images have been produced within discourses implicit in the colonial project. As Gayatri Spivak reminds us, "the production of historical accounts is the discursive narrativization of events".[29] Key examples of the way this worked in India have been exposed in the *Subaltern Studies* series. Ranajit Guha for example, cites the broad range of primary sources that contain information on peasant rebellions from "the exordial letter, telegram, despatch and communiqué to the terminal summary, report, judgement and proclamation"[30] as well as those secondary sources such as the reminiscences or retrospective accounts of administrators. While these accounts often conflict in their avowed purpose or in the information they contain on specific events, Guha points out that they are all written in what he variously calls the 'prose' or 'code of counter-insurgency'. In this code, an Islamic puritan becomes a *fanatic*, and revolt against the landlord becomes *defying the authority of the state*. While the record of events may often appear confused in these documents the intention in their being written in this way is not. Guha concludes that:

> These documents make no sense except in terms of a code of pacification which, under the Raj, was a complex of coercive intervention by the State and its protégés, the native elite, with arms and words.[31]

Shahid Amin examines legal documents and points out the paradox that "historians of colonial India have hitherto, by and large, coupled their political opposition to pronouncements made by English judges on the 'native' accused with an uncritical reading of judgements".[32] The judgement passed on the events at Chauri Chaura appears to satisfactorily explain the criminal acts of the crowd, as their picketing of liquor and meat shops is blamed on the prices charged by the shopkeepers. However, this record slyly turns a Hindu/Muslim declaration of unity (based on the issues of temperance and vegetarianism) charged through with religious and political

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[29]G.Spivak, 'A Literary Representation of the Subaltern: Mahasweta Devi's 'Stanadayini'', in R.Guha (ed), *Subaltern Studies V* (Oxford University Press 1987), p92.
[30]R.Guha, 'The Prose of Counter-Insurgency', in R.Guha, *Subaltern Studies II* (Oxford University Press 1983), p4.
[31]Ibid., p15.
[32]S.Amin, 'Approver's Testimony, Judicial Discourse: The case of Chauri Chaura', in R.Guha, *Subaltern Studies V* (Oxford University Press 1987), p167.

implications, into a simple act of wanton criminality by a typical mob. The economistic explanation entered in the records is formed within a colonial political discourse, where the demonstration of dissent is emptied of political significance by the act of recording the causes as economic. As Amin concludes: "An economistic reading of the evidence did not yield a politics of the accused, but it has of the judgement itself".[33]

It is not just colonial knowledges which come under suspicion when the relationship between words and power is exposed, but knowledges *per se*. As such medical texts have been scrutinised and medical knowledge has itself been accused of being no more than "a set of social messages wrapped up in technical language".[34]

Medical representations on this reading suffer the same problems as those of colonial representations, they are not simply pure or objective reflections of a reality out there, but constructions from within a set of variable discourses. Sander Gilman asserts that

> medicine uses its categories to structure an image of the diversity of mankind; it is as much at the mercy of the needs of any age to comprehend this infinite diversity as any other system which organizes our perception of the world.[35]

The processes of gathering medical knowledge and the classificatory systems based on these processes are all implicated. "Diagnosis emerges as the product of a number of overlapping discourses ... a construction for ever in the making"[36] in a study of childbirth in India, America and Canada, while disease categories appear equally fabricated:

> When we speak of tuberculosis we are not reading the label on a discrete portion of nature 'out there'; we are instead-it is argued-employing a social meaning that has been generated.[37]

Such reflections on the relationship between colonial and medical knowledges and the power relations of the circumstances in which they were implicated does not rule out any exploration of the sources available for the lunatic asylums of colonial India for the historian. Chapter I shows how an exploration of the power/knowledge

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[33]S.Amin, 'Approver's Testimony, Judicial Discourse', p198.
[34]R.MacLeod and M.Lewis (eds.), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (Routledge London 1988), intro.p1.
[35]S.Gilman, 'Black Bodies, White Bodies: toward an iconography of female sexuality in late nineteenth century art, medicine and literature', in H.L.Gates (ed.), *Race, Writing and Difference* (Chicago University Press 1986), p224.
[36]S.Lindebaum and M.Lock (eds.), *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, (University of California Press 1993), intro.p5.
[37]P.Wright and A.Treacher (eds.), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh University Press 1982), intro.p10.

relationship in the colonial context of the asylum renders problematic conventional approaches to asylum data. However, it also shows how such an exploration of the discursive cirumstances in which asylum records were produced gives the historian an insight into the way the British perceived themselves and Indians in the colonial relationship and the way that these perceptions could be reproduced in 'scientific' documents. The case note as the basic unit of asylum documentation is the focus of this chapter.

Yet the case note narrative is only one instance of the technology of producing knowledge. Statistical data grew in importance throughout the nineteenth-century, and this form of knowledge has also been accused of being less a true reproduction of external realities and more a productive process in which objects and subjects are created. Donald MacKenzie points to Eugenics theory at the end of the nineteenth century as an example of scientific knowledge produced by statistical data which reflected certain class interests[38] and Ian Hacking christens the productive process involved in statistical analysis of society in the nineteenth century "dynamic nominalism".[39] He concludes that

> new slots were created in which to fit and enumerate people. Even national and provincial censuses amazingly show that the categories into which people fall change every ten years. Social change creates new categories of people, but the counting is no mere report of developments. It elaborately, often philanthropically, creates new ways for people to be.[40]

In the second half of the nineteenth century in British India there was the development of a system to produce "a statistic that could generate a synthetic understanding of the whole of Indian society",[41] and there was correspondingly an "enormous growth, change and increasing complexity of Orientalist knowledge [which] ... broke society into groups, households and individuals making them available for piecing together through statistics".[42] These processes are familiar as Hacking's 'dynamic nominalism', and Bernard Cohn's exploration of the epistemological privileging of

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[38]D.MacKenzie, *Statistics in Britain 1865-1930: the social construction of scientific knowledge* (Edinburgh University Press 1981), p72.
[39]I.Hacking, 'Making Up People', in T.Heller, M.Sosna and D.Wellerby (eds.), *Reconstructing Individualism: autonomy, individuality and the self in Western thought* (Stanford University Press 1986), p222.
[40]Ibid., p223.
[41]Richard Saumarez Smith, 'Rule by records and rule by reports: complementary aspects of the British Imperial rule of law', in *Contributions to Indian Sociology* 19 (1) 1985, p173.
[42]G.Prakash, 'Writing Post-Orientalist Histories of the Third World: Indian historiography is good to think', in N.Dirks (ed.), *Colonialism and Culture* (University of Michigan Press 1992), p357.

caste as the key to knowing Indian society through the processes of the census seems to be an excellent example of counting creating human types in a colonial setting.[43]

This theoretical appraisal of statistical data as productive knowledge informs Chapter II in confronting the figure of the 'ganja-smoker' which became such a concern of colonial government in the last decades of the nineteenth century. A common project for historians is to survey the statistics available at the asylums in order to discern the truth they claim to be presenting. This only serves to implicate him/her in the reproduction of the discourses which created the statistics he/she is considering. It is the categories and types of human invented through the enumerative processes of the asylum which will be explored here. Chapter I may explore the ways in which knowledge was produced at the asylum but Chapter II shows how that knowledge itself could be productive.

The Asylums and Power: colonial and medical discipline.

The power relations of colonialism and medical authority are manifest in the documents produced at the asylum, in their form, in their content and in their very being. Yet power manifested itself in other ways at the asylum, and the place of the institution in the disciplinary procedures of the colonial state becomes a concern. This concern reflects an awareness of both the disciplinary functions of the psycho-sciences during the nineteenth century in the European experience and the attempts at reordering and regulating populations which typifies the colonial encounter.

The disciplinary functions of the psycho-sciences were first highlighted by Michel Foucault in his classic work on insanity in Western culture, *Madness and Civilization.*[44] This account has it that the origins of the asylum were as an institution where errant individuals identified as such by bourgeois morality[45] could be confined as punishment and be reformed. The walls of confinement enclosed "fortresses of moral order ... in which were taught religion and whatever was necessary to the peace of the state".[46]

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[43]B.Cohn, *An Anthropologist among the Historians and Other Essays* (Oxford University Press 1987), pp224-254.
[44]M.Foucault, *Madness and Civilization: a history of insanity in the Age of Reason*, (Routledge London 1989).
[45]"This strange republic of the good which is imposed by force on all those suspected of belonging to evil", in ibid., p61.
[46]Ibid., p62.

According to Foucault, by 1800 the doctor had taken on the responsibility for the reformatory procedures within the 'walls of confinement', so that "what we call psychiatric practice is a certain moral tactic contemporary with the end of the eighteenth century, preserved in the rites of asylum life and overlaid by the myths of positivism".[47] The asylum is a disciplinary site and the psychiatric practices were disciplinary techniques, where surveillance, judgement, patriarchy and physical coercion are combined and focused on the individual to "impose in a universal form, a morality that will prevail from within upon those who are strangers to it".[48]

Subsequent studies of the psycho-disciplines have confirmed their disciplinary functions. Andrew Scull identifies two stages in the development of the psycho-sciences in Britain and America which reflect alternative approaches to the disciplinary task:

> There is an abandonment of external coercion (which could never do more than force the crudest and least stable forms of outward conformity) for an approach that promises to produce the internalization of the necessary moral standards, by inducing the mad to collaborate in their own recapture by the forces of reason.[49]

In the same vein feminist writers emphasise the function of the psycho-sciences in disciplining the female sex, Elaine Showalter identifying 'the Darwinian nerve-specialist', who "arose to dictate proper feminine behaviour outside the asylum as well as in it, to differentiate treatments for 'nervous' women of various class backgrounds, and to oppose women's efforts to change the conditions of their lives".[50] Yannick Ripa who writes on the French experience concludes that, "this new 'alienist' medicine flirted with religion, morality and the police; in a sense it became the keeper of the public order".[51] She stresses that,

> the asylum sought to force women back into the mould from which they had just tried to escape. Sick from lack of attention and understanding, women were supposed to be 'cured' without being either heard or understood. Behind the paternalistic philanthropy of the asylum there lurked violent forms of therapy whose aim was to silence women ... Alienist science as applied to women was at its birth a socially coercive form of medicine.[52]

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[47]M.Foucault, *Madness and Civilization*, p276.
[48]Ibid., p259.
[49]A.Scull, 'Humanitarianism or Control? Some observations on the historiography of Anglo-American psychiatry', in S.Cohen and A.Scull (eds.), *Social Control and the State* (Basil Blackwell Oxford 1985), p134.
[50]E.Showalter, *The Female Malady: women, madness and English culture 1830-1980*, (Virago London 1987), p18.
[51]Y.Ripa, *Women and Madness: the incarceration of women in nineteenth-century France*, (Polity Cambridge 1990), p3.
[52]Ibid., pp160-1.

Indeed, studying psychology in England from 1869 to 1939, Nikolas Rose concludes that what the various strands of theory and practice "made possible was a scientific technique for the administration of individuals and populations in terms of their mental attributes and capacities".[53] Quite simply, the psycho-sciences provided the means not only for disciplining individuals but also for disciplining, that is managing and governing, whole societies.

If the psycho-sciences were complicit in disciplinary projects in modern Europe then their role in the colonial project must be questioned. After all the colonial project is often represented as the quintessential disciplinary experience where non-Western cultures, societies and minds are appropriated, controlled and reordered to suit the demands of the West. Frantz Fanon gives the classic account of this process in pointing out that "there is no occupation of territory, on the one hand, and independence of persons on the other. It is the country as a whole, its history, its daily pulsation that are contested, disfigured, in the hope of final destruction".[54]

Fanon, himself a Western trained psychiatrist, identified medicine as central to the colonial project, asserting that the doctor was implicated in the disciplinary machinery of the colonial state and that "the colonized perceives the doctor, the engineer, the school teacher, the rural constable through the haze of an almost organic confusion".[55] Others have concluded that Fanon is right to see medicine in this way, Roy MacLeod stating that "the history of medicine in empire refers to the ... history of medical regimes as participants in the expansion and consolidation of political rule",[56] and David Arnold venturing that

> whereas in the pre-colonial past health and medical care were matters for individual initiative or at most communal effort, under imperial rule they became part of a wider process of state regulation and centralised control.[57]

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[53]N.Rose, *The Psychological Complex: psychology, politics and society in England 1869-1939* (Routledge London 1985), p227.
[54]F.Fanon, *Toward the African Revolution*, (Monthly Review Press New York 1967), p65.
[55]F.Fanon, 'Medicine and Colonialism', in J.Ehrenreich (ed.), *The Cultural Crisis of Modern Medicine* (Monthly Review Press New York 1978), p229.
[56]R.MacLeod, 'Introduction', in R.MacLeod and M.Lewis, *Disease, Medicine and Empire: perspectives on western medicine and the experience of European expansion*, (Routledge London 1988), p2.
[57]D.Arnold, 'Introduction', in D.Arnold (ed.), *Imperial Medicine and Indigenous Societies*, (Oxford University Press 1988), p18.

Various case studies provide the evidence for such conclusions. In India and Africa population movement was controlled in the name of medicine,[58] while there are instances where surveillance and detention of the colonised was authorised with reference to medical measures.[59] India also provides interesting examples where behaviour was regulated after the introduction of sanitation projects.[60] The colonised populations were watched, controlled and reordered by medicine.

The place of the psycho-sciences in the disciplinary projects of colonial medicine has recently been explored in certain case studies. In Australia, Cathy Coleborne concludes that in the nineteenth century, "the preservation of social order remained paramount in the intentions of the legislators in early Australia where lunacy was concerned".[61] Sally Swartz identifies the unemployed members of the colonised population as of special concern to the authorities in the Cape Colony and finds the 'loose native', the unemployed and vagrant member of the urban masses, a regular admission to the Valkenberg asylum.[62]

Surprisingly though little attention has been paid to the Asian experience. Lee's article on the asylums of Singapore is simply a descriptive account of their development ending with the conclusion that "the conditions at Singapore, which was considered a 'remote outpost' were not too bad, and her doctors and leading citizens enlightened men".[63] Waltraud Ernst's *Mad Tales from the Raj* deals only with asylums for the European insane in British India before 1858 although it does offer the interesting point that even when focusing on the Western population in colonial encounters the psycho-sciences acted to discipline, in this case labelling as mad those likely to tarnish the reputation of the British in order to have them removed from the colony.[64]

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[58]M.Harrison, *Public Health in British India: Anglo-Indian preventive medicine 1859-1914*, (Cambridge University Press 1994), pp117-138; M.Lyons, *The Colonial Disease: a social history of sleeping sickness in northern Zaire 1900-1940,* (Cambridge University Press 1992).

[59]R.Ileto, 'Cholera and the origins of the American sanitary order in the Philippines', in D.Arnold, *Imperial medicine*, pp125-144; D.Arnold, *Colonizing the Body: state medicine and epidemic disease in nineteenth-century India*, (Oxford University Press 1993), pp200-239.

[60]V.Oldenburg, *The Making of Colonial Lucknow 1856-1877*, (Princeton University Press 1984), pp96-144.

[61]C.Coleborne, 'Legislating lunacy and the body of the female lunatic', in Diane Kirkby (ed.), *Sex, Power and Justice: historical perspectives on law in Australia*, (Oxford University Press 1995), p95.

[62]S.Swartz, 'The Black Insane in the Cape 1891-1920', in *Journal of Southern African Studies* 21, 3, September 1995, pp399-415.

[63]Y.K.Lee, 'Lunatics and Lunatic Asylums in early Singapore 1819-1869', in *Medical History* 19, (1973), p34.

[64]W.Ernst, *Mad Tales from the Raj: the European insane in British India 1800-1858*, (Routledge London 1991), pp164-173.

The place of the psycho-sciences in the disciplinary projects of the British in colonial India will therefore be investigated here in two chapters. Chapter III locates the asylum alongside the police and prison systems detailed elsewhere[65] in the matrix of institutions and policies devised by the British to control the Indian population and limit its mobility and perceived volatility. Chapter IV examines how the regime inside the asylum was devised to give the British medical officer command of the incarcerated Indian's body and behaviour so that that body and behaviour might be re-moulded and produced to be efficient and obedient. In other words these two chapters focus on the place of the psycho-sciences in disciplining India on the macro-level, that is on the level of governing whole populations, and in disciplining India on the micro-level where individual Indian bodies were seized and drilled.

Indians and the Asylum.

> We also found that, when thinking about power, it was always necessary to think about resistance.[66]

To ignore the experience of those subjected by the processes of colonial and medical discourses and discipline is to comply with those discourses and disciplinary projects, as it allows the power of the subject and the strategies of the subjected to be neglected, forgotten and written out of history.

This issue is often simplified into a study of 'resistance'. For example, in studies of patients opposing the definitions and practices of the psycho-disciplines this tends to be the emphasis. Roy Porter points to autobiography as one method of resisting the discourses of psychiatry as it allows a space for self-definition[67]. Autobiography is also a theme developed by Jann Matlock in her discussion of the French asylum patient Hersilie Rouy.[68] For Yannick Ripa, resistance to internment took four different forms:

> First, there was clearly expressed opposition which came in the form of a letter complaining about the committal; next came rebellion against the authorities; then escapes and attempted

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[65]A.Yang, *Crime and Criminality in British India* (Univeristy of Arizona Press 1985); D.Arnold, *Police Power and Colonial Rule: Madras 1859-1947* (Oxford University Press 1986); D.Arnold, 'The Colonial Prison: power, knowledge and penology in nineteenth-century India', in D.Arnold and D.Hardiman (eds.), *Subaltern Studies VIII* (Oxford University Press 1994), pp148-187.

[66]N.Dirks, 'Introduction', in *Colonialism and Culture*, (Ann Arbor Michigan 1992), p14.

[67]R.Porter, *A Social History of Madness: stories of the insane*, (Weidenfeld and Nicholson London 1987), p231.

[68]J.Mattlock, *Scenes of Seduction: prostitution, hysteria and reading difference in nineteenth-century France*, (Columbia University Press 1994), p185.

> escapes; finally, general misbehaviour which expressed their feelings but affected the inmates themselves- for example, mutism and attempted suicide.[69]

Cheryl Krasnick Warsh similarly identifies letter writing, escape and suicide as instances of resistance in the Canadian Homewood Retreat but also points to violent and disruptive behaviour, all too easily disguised by the authorities as symptoms of an illness rather than as coherent expressions of anger, as behaviour indicating opposition to the situation in the asylum.[70] Indeed madness itself has been interpreted as resistance, where behaviour which refuses to conform to that expected is given the label 'insane' so as to justify disciplinary action and to discourage others from adopting that approach. This is an argument advanced in a number of feminist accounts of madness, Phyllis Chesler for example claims that women in American mental institutions in the nineteenth century did no more than behave in ways which defied male imposed norms of female propriety.[71]

Colonial studies though emphasise the perils of only looking for resistance when considering the responses of the subjected, as this accepts that the subjected can only express themselves in opposition to something, on grounds and in situations defined by others. For example the Subaltern Studies project identifies the politics of the lower classes as an 'autonomous domain' in the culture of colonialism which, "far from being destroyed or rendered virtually ineffective, as was elite politics of the traditional type by the intrusion of colonialism ... continued to operate vigorously in spite of the latter".[72] Nicholas Thomas also develops this theme, exploring the possibility that

> 'natives' often had relatively autonomous representations and agendas, that might have been deaf to the enunciations of colonialism, or not so captive to them that mimicry seemed a necessary capitulation.[73]

Thomas also urges the importance of exposing, "the limitations of the assumption that 'colonial discourse' is automatically apparent to the colonized in the first place".[74] His

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[69]Y.Ripa, *Women and Madness,* p138.
[70]C.K.Warsh, 'Moments of Unreason: the practice of Canadian psychiatry and the Homewood retreat 1883-1923', quoted in C.Coleborne, *Resistances and the negotiation of 'mad' identities*, (unpublished paper), p5.
[71]Phyllis Chesler, *Women and Madness*, (Allen Lane London 1984), p16.
[72]R.Guha, 'On Some Aspects of the Historiography of Colonial India', in R.Guha (ed.), *Subaltern Studies I*, (Oxford University Press 1982), p4.
[73]N.Thomas, *Colonialism's Culture: anthropology, travel and government*, (Polity Press Oxford 1994), p57.
[74]Ibid.

evocation of Aguirre as an image of the colonial experience, with the conquistador unnoticed and alone in a vastness narcissistically and extravagantly declaring possession of all around him, is an important one as it reminds the historian that the Fanonian vision of the colonial impact as "societies drained of their essence, cultures trampled underfoot, institutions undermined, lands confiscated, religions smashed, magnificent artistic creations destroyed, extraordinary possibilities wiped out"[75] is not the only understanding of the colonial encounter available and may indeed itself be complying with the colonizers' self-representations which stress the significance and omnipotence of their project .

The responses of the patients in the Indian asylums will be considered then in Chapter VI, as the responses of those caught up in medical and colonial systems of power. This will not be the only group whose response will be explored there as Indians interacted with the asylums in a number of ways. The majority of the staff were Indian, working in various capacities from that of sub-assistant surgeon to orderly to sweeper and gardener. In other words, it was not just the patients in the asylum who were encountering colonial systems, as work-discipline and Western medicine framed the experience of those employed.

The evidence also suggests that members of the local community were not simply passive participants in the colonial/medical system, as patients or internees gathered in by disciplinary practice, but actively sought to interact with the asylum by seeking admission for themselves and for members of their friends or family while pursuing the release of others. Their agendas in dealing with the colonial institution lie at the heart of the colonial experience, as they raise the possibility that it was not simply the colonizers who had the power in deciding the character and outcome of that experience. It is the interaction of the community around the asylums with those colonial institutions that will be the subject of Chapter V.

It needs to be emphasised that it is the interaction of the non-elite members of Indian society with medical institutions which will be the focus. Superintendents frequently made comments similar to the following about asylum admissions:

> The three classes whence the largest number are received are ryots, servants and beggars.[76]

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[75] A.Césaire, 'Discourse on Colonialism', quoted in E.Hansen, *Frantz Fanon- Social and Political Thought*, (Ohio State University Press 1977), p71.

[76] *Report on the Asylums, Vaccination and Dispensaries in Bengal, 1868-1873,* p13.

The evidence on the case notes from the Lucknow lunatic asylum confirms this, as the usual entries under occupation are 'beggar', 'labour' [sic], and 'cultivator' and where caste information is given low status categories like 'chumar'[77] and 'ahir'[78] are common. In other words it seems that the asylum was dealing with subaltern groups in Indian society and it is the interaction of such groups with the colonial institutions which will be considered.

[77]Case Book IA, patient no.163, admitted 3 April 1865: 'chumar' means leatherworker.
[78]Case Book IA, patient no.158, admitted 28 February 1865: 'ahir' means herdsman.

CHAPTER I.

The Asylum Archive: Discourse and the Production of Colonial Knowledge.

CHAPTER I. THE ASYLUM ARCHIVE: DISCOURSE AND THE PRODUCTION OF COLONIAL KNOWLEDGE.

Tracing the time and effort expended in the early 1870s on deciding the form of the end of year statistical report demonstrates the importance attached to the collection and compilation of information at the asylum. The Inspector-General of Hospitals in the Indian Medical Department in Calcutta effected a series of reforms in the report in Bengal early in the decade. Circular Memorandum No.105 of 1871 instituted a system of sixteen tables that each asylum in Bengal had to include with the annual report and included the note: "The Inspector-General of Hospitals observes that some diversity exists in the forms of Statistical Returns of Lunatic Asylums. As it is essential, for purposes of comparison and compilation, that these forms shall be uniform, the following illustrations of those which should be invariably appended to the Annual Report have been prepared".[1] Cuttack asylum had submitted thirteen tables the year before this memorandum, Moydapore nine and so on reflecting the difference in practice of individual asylums. The new system standardised the way information was presented on issues which had previously been tabulated in different ways by the different asylums such as the type of madness diagnosed and called for statistical representations on new issues such as the rates of mortality compared to duration of residence.

It was then suggested in 1872 that these forms be adopted by the Government of India for all the asylums under its jurisdiction. In forwarding copies of his new tables the Inspector-General explained:

> It is desirable in the first place that I should indicate clearly the objects and uses which these forms are intended to subserve. Their main object is to exhibit- *firstly*, the condition under which insanity arises among a community; and *secondly*, the circumstances and appliances under which recovery from insanity occurs. A knowledge of these conditions and circumstances is necessary for the adoption of means towards the prevention and cure of insanity and the more carefully and systematically they are noted and exhibited the more power we possess in both directions.[2]

His forms were not accepted by all and the ensuing controversy was settled by the referral of the matter to a committee in 1873. They gave their opinion and the Government of India tinkered with their suggestions and finally a Resolution was passed in 1874.[3] However this Resolution only offered the chosen tables as the

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[1] *Annual Report on the Insane Asylums in Bengal for the Year 1871*, p83.
[2] IGH.IMD to GOI 6 January 1873, GOI (Public) Procs January 1873, 529A.
[3] See GOI (Medical) Procs September 1874, 60-63A.

suggested standard and did not impose them as the expected norm and asylums certainly chose to continue with their own preferred systems.[4]

Because of the significance attached at the time to information at the asylum there is a healthy set of records available to the historian for exploring the asylums of British India. These will be explored in two parts. The first, which concerns this chapter, will look at the nature of the data collected and will discuss in detail the problems that that nature presents to conventional histories and the possibilities which that nature raises for exploring the power/knowledge relationship in the colonial context. The second part, which forms the next chapter, will look at the way that the asylum acted as a site where knowledge of India was produced which fed into the wider context of colonial government through the medium of statistics, a process through which human types like the 'ganja-smoker' were invented.

Approaching the Asylum Data.

As was mentioned earlier, a host of materials and sources survive concerning the asylums of India, including the end of year reports with detailed statistical tables enumerating information on all matters from the number of patients in each religious group to the average cost per patient, individual patient case notes on which the details of what the doctor has observed of the individual patient are recorded and lengthy articles in professional journals in which theoretical matters are discussed and strange symptoms recorded. This seems fairly standard material for asylums after 1850 the world over, and a number of accounts have used such sources in an attempt to reconstruct the asylum experience of the nineteenth-century. The two projects of Allan Beveridge in publishing *Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston 1873-1908*[5] may be taken as fairly representative of the projects of many historians when confronted with such sources.

The first of these projects is the exhaustive collation of the statistical data available for a specified series of years to establish information on the amount of patients treated in each age group, the length of duration of stay, the numbers diagnosed under each type

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[4]For example see the *Report on the Lunatic Asylums in the Central Provinces for the Year 1874* (that was prepared and submitted in 1875). This was the year that the Resolution was passed, but the summary for Nagpur includes ten tables, Jubbulpore eleven.

[5]A.Beveridge, 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston 1873-1908' Part I in *History of Psychiatry* vi (1995), pp21-54; Part II in *History of Psychiatry* vi (1995), pp431-451.

of madness etc.[6] in other words to create a profile of the patient population. The second of these projects is retrospective diagnosis, where the appropriate late twentieth century label is applied to the symptoms recorded in the case notes of the past. This latter exercise is designed to reveal what types of mental illness, as understood by the more advanced and scientifically validated systems of today, were being treated in the hospitals of previous ages.[7]

These are not the approaches to be adopted here in using the texts available for the asylums in British India for two reasons. The first is that there are serious doubts, some of which are contemporary with the compilation of the records themselves, about the quality of the information included in asylum documents. The second reflects the doubts raised about historical texts in the introduction. Similar concerns exist amongst both medical and colonial historians that the representations available to them in source materials are less accurate reproductions of some external reality and more productions of discourses linked to the power relations of the period. When examining psychiatric case notes it must be remembered that the data to be collected on somebody deemed mentally disordered is not self-evident. A North Indian *pir* concerns himself primarily with dream content,[8] while the asylum case notes at Lucknow show that a nineteenth century colonial doctor concerned himself largely with the body of the patient. The reasons why certain observations were made and certain details were recorded need to be explored in order to explain the historical significance of the documents which survive from the asylums of the period.

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[6]See also A.Digby, *Madness, Morality and Medicine. A study of the York Retreat 1796-1914*, (Cambridge University Press 1985); P.Alleridge, R.Hunter and I.MacAlpine, *Psychiatry for the Poor. 1851 Colney Hatch Asylum-Friern Hospital 1973* (Dawsons London 1974); N.Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping 1840-1883* (Cambridge University Press 1984); S.Short, *Victorian Lunacy: Richard M.Bucke and the Practice of late Nineteenth-century Psychiatry,* (Cambridge University Press 1986).

[7]See also T.H.Turner, 'Schizophrenia as a Permanent Problem', *History of Psychiatry* iii (1992), pp413-429; E.Renvoize and A.Beveridge, 'Mental Illness and the late Victorians: a study of patients admitted to three asylums in York 1880-1884', in *Psychological Medicine* xix (1989), pp19-28; R.Persaud, 'A comparison of symptoms recorded from the same patients by an asylum doctor and a 'Constant Observer' in 1823: the implications for theories about psychological illness in history', in *History of Psychiatry* iii (1992), pp79-94.

[8]S.Kakar, *Shamans, Mystics and Doctors: a psychological enquiry into India and its healing traditions*, (Oxford University Press 1982), p47.

Counting and Retrospective Diagnosis.

Counting.

Even if it were desirable to collate the information available and from it to build statistical pictures of the asylum population there would be serious problems with any conclusions as it seems that the reliability of the data cannot be assumed. Simple data like the age of the patient was recorded on every case note that has been examined, was collated in the tables of the end of year annual reports and was routinely commented upon in conclusions like the following:

> The tendency to insanity is most distinctly marked in the third and fourth decennia of life; it is less marked between the 40th and 60th years of age, still less marked under 20 years of age and reaches its minimum as old age advances.[9]

Yet serious doubts can be raised about the accuracy of the ages entered on the case notes. Of the 721 notes, 508 have ages which are entered as multiples of 5, in other words about 70% of the patients were entered as being 15, 20, 25, 30 etc. years old upon admission. This suggests a process of estimation at work on the part of the medical officer filling in the case note (or alternatively that there is a fearful correlation between insanity in nineteenth century Lucknow and reaching an age which is a round number). Indeed, entries on the case notes seem to support the idea that an age was entered for a patient which might later be changed as more information, from relatives or the patient him/herself became available. Patient no.110 in the first volume of case notes was admitted in May 1861 and discharged in January 1862.[10] He was judged to be 12 years old when the case note was first filled in and yet in the same box there is pencilled in the figure 18. He was not in the asylum for six years so this new figure does not reflect an attempt to record his age on discharge. Rather it shows a revision of the record of the man's age.

Lobha was admitted in August 1868 and died in November 1869. Originally judged to be 27 years old, a thick, black line through this figure suggests dissatisfaction with this information and a new figure of 50 is entered.[11] Neither was age, when revised, always revised upwards, as Kovingbeebaree who was admitted and discharged in the

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[9]*Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78*, p5.
[10]Case Book IA, patient no.110, admitted 30 May 1861.
[11]Case Book IV, patient no.54, admitted 31 August 1868.

summer of 1864 was originally recorded as being 20 years old, an estimate that was replaced with the figure 14.[12]

While the Lucknow case notes are the only available for the period 1859-1872, materials from Indian asylums for a later period suggest the process of estimating age was not limited to the doctors at the Lucknow asylum in the 1860s and 1870s. It was pointed out in Bombay that "Deputy-Surgeon General Maitland objects to the tables ... he also considers there will be difficulty in obtaining the age etc. of insanes".[13] Jabu Sheikh was a patient of Dr. Robertson-Milne in Bengal in 1910.[14] On his case note under the 'age' heading is:

40! (25!)

What age Jabu Sheikh was in 1910 is open to question, as is the age Dr. Robertson-Milne thought him to be. What is clear though is that there was no definite information on this point and that a process of estimation was adopted, which in this case was frustrating the medical officer.

Data on more complex issues like cause of madness or even the type of madness that the patient was deemed to be suffering from is similarly problematic and cannot be taken as reliable information on reality. The problems of collecting information on the cause of madness will be discussed in a subsequent exploration of the statistics on ganja smoking. The difficulties in using the data on the type of madness diagnosed and treated in the asylums though are of concern here. In 1867 for example, Dr. James Wise, who was to go on and publish articles on insanity in India in professional journals,[15] included the following table in his end of year report on the Dacca asylum.[16]

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[12]Case Book II, patient no.106, admitted 10 June 1864.
[13]*Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1873-4*, p6.
[14]Robertson Milne-Collection LHB7/58/2 (20).
[15]J.Wise, 'General Paralysis of the Insane', in *Indian Medical Gazette*, vol.IV, 1869, pp75-76.
[16]*Asylums in Bengal for the Year 1867*, p60.

nature of insanity	remained 31st Dec.1866	admitted during the year 1867	total	males	females	total
amentia	1	0	1	1	0	1
dementia	73	9	82	65	17	82
mania acute	1	9	10	8	2	10
mania chronic	132	47	179	158	21	179
monomania	7	11	18	15	3	18
moral insanity	2	1	3	2	1	3
total	216	77	293	249	44	293

Table I. Table showing the types of madness at the Dacca Lunatic Asylum in the year 1867.

From such a table it would be possible to conclude for example that most lunatics admitted to the Dacca were chronic maniacs, just as Allan Beveridge reproduces the statistics in Edinburgh to discover that "during Clouston's period of office the commonest clinical conditions identified using the traditional M.P.A. classification were those of mania and melancholia".[17] The difficulty in using these statistics is that without knowing when mania, melancholia etc. were applied as labels it would be impossible to understand what types of behaviour were being treated in the asylum. Beveridge overcomes this difficulty by including examples that he calls 'representative', so that for mania there is the example from the Edinburgh case notes of Andrew J. who is "intensely excited"[18] and was "talking incessantly", for melancholia James S. who was suicidal, etc.[19] Other historians aware of this difficulty use alternative approaches. Anne Digby in her study of the York Retreat adopts a different way of making sense of the nineteenth century categories, so that after exhibiting a table of the diagnoses of first admissions between 1796 and 1843 she offers modern equivalents to the old labels: "Manias and melancholy approximate broadly to manic-depressive illness: moral insanity to personality disorder; idiocy and imbecility to mental handicap; and dementia to dementia".[20]

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[17]A.Beveridge, Part II, p134.
[18]Ibid., p135.
[19]Ibid.
[20]A.Digby, *Madness, Morality and Medicine*, p136.

Such an approach is deeply problematic, certainly in the Indian instance, because of comments like the following from medical officers working in the asylums of the period:

> On the question of the nomenclature and the difficulties in the classification of some forms of mental diseases, the following careful note occurs in Dr. Crombie's report- 'Every year references are made to the uncertainty of nomenclature in the hands of different Superintendents. As a matter of fact, there is room for difference of practice. The prevailing type of insanity in this part of India is that which is manifested by eccentricity, loquacity and general joyfulness and absurdity of demeanour, generally without delusions and with no loss of intelligence. These cases I class as chronic mania as they exhibit exaltation of the emotional faculties. But they often pass into a condition of chronic dementia when the emotional excitement becomes combined with diminished mental power. It is possible that one observer may classify such a case of chronic dementia, while another noticing the exaltation of emotion would enter it as one of chronic mania. The diagnosis between melancholia and dementia is not always easy. In both there is the same abstraction and disregard of surroundings, similar solitary habits and silence or reluctance to speak, and perhaps similar disregard of decency and personal cleanliness; but in one case these symptoms are due to the mind being so completely occupied by one thought of fear or misfortune or sorrow that it leaves no room for any other consideration, and in the other case the mental faculties are so degraded as to be incapable of being roused to an appreciation of what is taking place. On the other hand, the distinction between dementia and imbecility is dependent on the history of the case. If the mental degradation has occurred after the full development of the mental faculties it is a case of dementia; if it is due to arrest of development of the mental power in infancy it is a case of imbecility. The descriptive rolls on which the diagnosis depends are generally altogether worthless: they either contain no information whatever or are quite untrustworthy. Again, recurrent acute mania, whether that which follows epileptic attacks, or some unknown cause might, by one who regards chiefly the chronicity of the cause, which often lasts many years, be entered as chronic mania; while another having regard only to the acuteness of each individual attack would return it as acute mania... In nature, the several types of insanity are not clearly defined: they dovetail, overlap and merge into one another, and as the case progresses the type of insanity often changes altogether.[21]

In other words, in practice the label applied to a certain type of behaviour might vary from asylum to asylum and from medical officer to medical officer. This doubt about diagnosis and classificatory systems is reflected in the variety of systems used in end of year reports. Dr. Wise, writing in the same report as the one in which he included the above table comments that:

> In his report on the Insane Asylums for 1866, Dr. Green remarks upon the different classification of mental diseases followed in this asylum from that adopted at Dullunda. On referring to the reports of former years, I find that Dr. Simpson in 1862 distinguished between 9 varieties of insanity. In the reports for 1863 and 1864 8 classes only are enumerated; mania being subdivided into chronic and recurrent, and dementia into primary and secondary. In the report for 1865 only 5 classes are noted, mania chronic and dementia being made to include the subdivisions of former years. In 1866 the same nomenclature was followed. It has been found impossible to alter the classification of the present report. as the monthly returns and case books have been filled in accordance with it.

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[21] *Asylums in Bengal for the Year 1885*, p3.

> It would be easy to adopt 'a uniform standard of distinction' in all asylums, but the orders on this subject are vague. The circular letter of the Medical Board no.25, dated 13th July 1854 leaves it to the option of the Superintendents to follow one of two classifications; but it directs that if the minute subdivision is adopted, the varieties must be included under the 5 heads of moral insanity, monomania, mania and amentia. The table in the revised rules of 1860 only recognises these five divisions.[22]

What is clear in this passage is that the problem of diagnosis and classification was one that dated back at least until the 1850s and that attempts to impose at least a standard way of recording this data had failed. More remarkably it shows how the records of one asylum changed between doctors and year by year. Diagnosis and classification was an issue in the 1850s and 1860s as much as it was in the 1880s and it should be noted from examples from other administrations in India that this was not a problem specific to the institutions in Bengal. In 1879 A.H.L.Fraser in the Central Provinces wrote, with a hint of exasperation, in his overview of the asylum reports that:

> As regards the types of insanity, there would appear to be considerable difference in the systems of classification observed. 'Chronic Mania' and 'Chronic Dementia' are credited with nearly two-thirds of the cases treated. In Nagpur 59 are set down to the former, and 35 to the latter, while in Jubbulpore the figures are 22 and 62 respectively. Similarly for 'acute mania' and 'acute dementia' the figures for Nagpur are 21 and 5, and those for Jubbulpore 7 and 11. Again 'idiotcy' of which no cases are recorded at Nagpur has 39 in the Jubbulpore asylum while 'melancholia' and 'insipientia' have far more cases in the former than in the latter institution.[23]

These problems with the meaning to be attached to each diagnostic category used render the statistics extremely problematic as counts of people suffering from specific conditions or behaving in specific ways for, as is clear from Dr. Crombie's lengthy account, the variety of classificatory systems which existed is the result of certain actions or appearances being included under different headings by different doctors. In other words there is no evidence that categories like 'mania' or 'melancholia' were stable ones, so that it is impossible to be sure that one person to whom the label 'maniac' had been attached was behaving in the same way or exhibiting the same symptoms as another person from a different asylum, period or under the jurisdiction of another doctor to whom the label 'maniac' had similarly been attached.

The annual reports of the asylums compiled statistical summaries of the year under the categories of information routinely gathered about the patients. The information under

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[22] *Asylums in Bengal for the Year 1867*, p42: The five headings referred to here are moral insanity, monomania, mania (acute and chronic) and amentia.

[23] *Asylums in the Central Provinces for the Year 1878*, p2.

supposedly simple categories like that of the age of the patient is open to doubts about its accuracy and so any conclusions based on the statistical summaries of such data necessarily ignores all the evidence of inaccuracy and fabrication. More complex categories like that of type of mental illness suffered are similarly problematic as it is not at all clear what these categories refer to in clinical practice. In short, statistical profiling by historians of the patient population which involves the straightforward compilation of the available data into neat numerical summaries does no more than reproduce the loose and confused practices of the period when the information was originally collected.

Retrospective Diagnosis.

The doubts about the diagnostic data in asylum materials also makes any attempt at retrospective diagnosis especially difficult were it deemed desirable to attempt this project. Allan Beveridge certainly feels it is a desirable project, and using the information contained on the patient case notes at the Edinburgh asylum attempts to re-diagnose Clouston's patients in a modern idiom. Thus he concludes, for example, that

> it is apparent that organic illness featured prominently in the Asylum population, especially amongst West House patients ... comparatively few patients met the criterion for schizophrenia although the numbers were higher for East House patients.[24]

There are those who would argue that retrospective diagnosis is anything but a desirable or sensible project as far from being a scientific exercise, the conceptualization of old diagnoses in terms of modern categories involves no more than simply translating one pack of social constructions into a more contemporary set of fabrications. Mary Boyle[25] for instance suggests that the current term 'schizophrenia' certainly has little scientific validity and its formulation and continued usage reflects instead varying interests such as the claims to medical expertise of the psychiatric profession. Some writers, such as Thomas Szasz, have questioned the legitimacy of the modern psychiatric project in its entirety, claiming that "psychiatric explanations and interventions are fatally flawed".[26] For such writers the use of modern diagnostic labels as an attempt to accurately represent the conditions of those whose symptoms are included in antique case notes would obviously be a pointless exercise.

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[24]A.Beveridge, Part II, p143.
[25]M.Boyle, *Schizophrenia: a scientific delusion?*, (Routledge London 1990).
[26]T.Szasz, *Insanity: the idea and its consequences*, (John Wiley New York 1987), p5.

Sally Swartz raises more specific objections to the exercise of retrospective diagnosis in her work on the asylum in the Cape Colony.[27] For example, she raises questions about its methodology, pointing out that it can involve the privileging of symptoms recorded which are translatable into modern categories and the setting aside of information which although on the case note is difficult to reconcile with those modern categories. She also suggests that the assumption that the original diagnosis on the case note and the symptoms recorded there remained fixed for that patient is a dangerous one to make.

Significantly though, she also finds a number of problems in the diagnostic categories of the Valkenberg asylum which would render retrospective diagnosis questionable. Quite simply, she shows how the information included on case records is not the result of purely scientific observation. Diagnostic patterns reflect professional interests, institutional strategies and medical improvisations. Perhaps most interesting of all for the present study is her suggestion that the cultural assumptions of the white doctors about the mentalities of the black patients influenced diagnostic behaviour. The colonial doctors thought that their black patients were fundamentally different from whites and that their mental experiences would reflect this, and Swartz claims that this was decisive in assessments of the experience of depression among black patients. So, the case notes and asylum records of the Valkenberg Asylum which she studies do not simply contain information formed by medical imperatives which those claiming medical expertise can then come along and assess. Rather these materials are produced in a political and cultural context, where assumptions and agendas reflecting power relations in the wider society can influence the details included in a medical document. The contemporary psychiatrist attempting retrospective diagnosis would be taking as medical data information which had been included (and indeed silences which had been included) to serve non-scientific, very political interests.

Overall then there are great dangers in taking information produced in the asylum at face value as it is rarely clear what it is referring to. A glimpse at the 'mania' column in the end of year report only allows a conclusion about how often that label was attached by medical officers, not how many people exhibiting certain behavioural characteristics were detained. Concentrating on the age column in the end of year reports results in a conclusion about the most likely and the least likely age at which a

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[27]S.Swartz, 'Changing Diagnoses in Valkenberg Asylum, Cape Colony 1891-1920', in *History of Psychiatry* vi (1995), pp431-451.

patient was liable to be estimated by a doctor at the asylum rather than establishing the age groups present in the asylum.

A focus on one specific set of asylum documents from the institutions in British India, the collection of case notes at the Lucknow lunatic asylum for the period 1859-1872, will demonstrate what was suggested earlier and is the emphasis of Sally Swartz's conclusions. Simply, the information contained in those documents is so problematic as it is less an attempt to capture an external reality and more a product of complex discursive circumstances. As such the information contained on the case notes reveals much more about the authors of the notes than about the patients they purport to describe.

The Case Notes: Narratives of Colonial Fantasy and Medical Legitimacy.

> Medical certificates issued by alienists strike one as imprecise and contradictory ... They do not seem too bad because they fulfil an administrative role and end up in the green files of La Préfecture.[28]

Although indeed the words of a Frenchman, this Foucauldian statement is neither his nor are they written under his influence. Written in 1914 by the French psycho-pathologist Pierre Chaslin after a lengthy career of writing the certificates he criticises it raises the issue of the discursive circumstances in which case notes were produced. He points to the bureaucratic function of the case note as being the context in which the content of case notes becomes intelligible. Others have argued that other discursive conditions can be identified. Jill Matthews looks at information for women at Glenside Hospital in Australia and emphasises the problems of using such case notes. They are neither autobiographical nor biographical as "they do not seek to understand a person's life in any terms other than those which further the interests of the institution compiling the notes".[29] For her, the case notes are complicit in "the masculine bias of our language and its organisation of reality".[30]

This emphasis is also that of Cathy Coleborne in her work on nineteenth century case notes at the Yarra Bend Asylum in Australia. She shows how the patient case note there served to construct rather than simply represent the patient as they produced "a

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[28]P.Chaslin, 'Is Psychiatry a well-made Language?', in *History of Psychiatry,* 1996 vol.6 part 3, p398.
[29]J.Matthews, *Good and Mad Women: the historical construction of femininity in twentieth-century Australia,* (Allen and Unwin St.Leonards 1984), p25.
[30]Ibid., p28.

gendered narrative about the lunatic asylum inmate".[31] She also points out that the case notes are constructed to read as a commentary on the efficacy of the asylum doctors in dealing with mental disorder and as such are justificatory texts for the power those doctors claim over their female subjects: "Medical discourse possesses a narrative of sickness which tells a story of the physician's ability to make a patient well through observation and the correct treatment".[32]

If medical historians then have pointed to the discursive web which surrounds the patient case note, colonial historians have similarly emphasised the discursive web which surrounds the colonial document. As was mentioned in the introduction, case studies by Shahid Amin and Ranajit Guha concern themselves with the relationship between the legal document in British India and colonial discourse.[33] They conclude that these documents produce versions of events which reflect the perceptions and imperatives of the colonisers and that these documents are useful to the historian less as records of those events and more as evidence of the politics of those composing the documents. This conclusion informs this study of the case notes of the Lucknow lunatic asylum as do the conclusions of those mentioned above who have worked with medical case notes: a study of the Lucknow materials locates the knowledge contained there firmly in colonial and medical discourses rather than in a direct relationship with any external reality.

Consider the following case notes.

> Jeeh Singh. m. Dementia. Hindoo. Cultivator. 28. 13 May/62.
>
> Sent from Oonao. Civil Surgeon certifies that he has been insane for 2 months from no apparent cause- at times very violent and disposed to smash everything which comes in his way. Replies very incoherently to questions.
>
> Shortly after admission he became much quieter- was regularly employed in the garden + improved in health + general appearance. I consider him now quite cured and he is discharged Aug.5 1862.[34]

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[31] C.Coleborne, 'Gender and the Patient case-book in the lunatic asylum in colonial Victoria (Australia)', presented to the Society for the Social History of Medicine *Medicine and the Colonies Conference*, Oxford 1996, p2.

[32] Ibid., p5.

[33] R.Guha, 'The Prose of Counter-Insurgency' and S.Amin, 'Approver's Testimony, Judicial Discourse: The case of Chauri Chaura', in R.Guha, *Subaltern Studies V* (Oxford University Press 1987).

[34] Case Book IA, patient no.194, admitted 13 May 1862.

Dabee Singh. Mania. Brahmin. Beggar. 40. 16 April 1861.

1861 April. This man was under observation in the Jail for sometime previous to his admission. There he complained that he was kept out of his just and lawful rights + demanded his release. He will eat nothing but sweetmeats. After a time his case was sent in from Hurdui from which it appears that he has been insane for the last three years. That he is not violent but very abusive of all without distinction. He is very much emaciated + suffers from diarrhoea, the effect of the sweetmeats on which alone he subsists.

June. In the last month has subsisted solely on melons. He eats 12 to 16 per day along with half a pound of chilli. Diarrhoea is less + altho' still there has laid on flesh.

1864 This man has been in rude health for the last two years- eats + sleeps well. No difficulty of dieting him. Has regularly worked in the garden- very solicitous for his discharge. Says he has a mother alive in the Hurdui district. Discharged cured 5th Oct 1864.[35]

Both seem to read as narratives of complete mental and physical recovery in both the male patients. Yet these case notes only read as such because of the types of information which has been included on those documents, information which is in fact quite specifically selected within certain modes of seeing the patient. The information on these documents can be separated into two categories. The first is data on the patient's physical condition, Jeeh Singh is 'much improved in health' while Dabee Singh has details of his diet, his emissions and his general physical appearance meticulously noted. The second is not simply data on the patient's mental condition as might at first be expected as he is a patient in an institution whose avowed aim is mental health, but on his compatibility with the colonial order, quite simply whether he is violent and disruptive or able to labour and be obedient.

The information contained in the notes is no simple reflection of a reality outside of those notes: the medical and colonial discourses of legitimacy and order inform the decisions made by the compiler of the case note about what impressions of the individual who is the subject of the document will be included in that document. In other words the totality of that individual is never captured in the document, rather the information in the case note organises a reality and creates an entirely new object.

[35]Case Book IA, patient no.94, admitted 16 April 1861.

> Mosst Bunnoo. Chronic Mania. 35. Moosulman. Beggar. 12th November 1870. Violent.
>
> 12th Novr 1870. Sent in by the Cantonment Magistrate of Lucknow for re-admission was discharged from asylum on the 5th Novr 1869.
>
> June 26. 1873. Admitted to hospital for diarrhoea.
>
> Jan 7. 1874. Bunnoo died this day. She has been insane for about 7 years + in hospital nearly 7 months. She had chronic diarrhoea + became anaemic.[36]

The importance of information about the physical condition of the insane patient throughout the period for which case notes are available is emphasised by the examples like that of Bunnoo above. Written in 1870, her entry reads like a chart of a physical demise rather than as a record of mental aberration. The record stresses that she was deemed violent by the Cantonment Magistrate and states simply that she was insane for the best part of seven years by the time she died. Yet the majority of the data concerns her physical condition, the date that her diarrhoea set in, the length of time that she remained afflicted with this bodily condition and the subsequent developments and complications in her physical state are all accorded sufficient significance to enter the case note. This degree of concentration on the physical health of the internee is evident in notes from earlier volumes as well.

> Bholah. m. Mania. 30. Hindoo. Cultr. 24 Jany/63
>
> 1863. Sent in by Deputy Commissioner Roy Bareilly was found wandering about cantonment there- on admission is much attenuated + suffering from dysentery, his intellect appears very much affected but there is also much bodily debility.
>
> March. This man gradually sunk since his admission- the dysenteric motions improved but he could not eat + the vital powers gradually exhausted. On 23d March, he died.[37]

The only reference to Bholah's mental state on the entire document is a brief mention of the fact that his mental state appears odd but this is not even expanded to the extent that observations on the ways in which this mental state manifests itself are included. The majority of the record is a series of observations on the man's physical condition and afflictions, mentioning his drawn out condition, his weakness and the progress of the disease thought to have a grip on his body.

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[36]Case Book IV, patient no.231, admitted 12 November 1870.
[37]Case Book II, patient no.6, admitted 24 January 1863.

A notable feature of the case notes is that death is always recorded when the patient expires in the asylum. Obviously there is a bureaucratic imperative operating here as a record of where an individual who is in the system ends up is necessary for purposes of internal accounting. However, what is remarkable about this record of death in a document that is ostensibly a record of a sufferer of mental ill health is that information on the causes of death, information that is of its essence a record of the physical causes of a physical demise, is rarely omitted. The above examples each contain details of the circumstances of death and often statements on the case notes are far more explicit. Bhola Dass "died in hospital from pneumonia"[38] while Goolabdie simply "died of general debility".[39] This is similar to Kunsee for who more details are available as she "died of debility the result of repeated epileptic fits"[40]. Elsewhere Gosalee "died of chronic diarrhoea",[41] while a couple of months later Shewrutton "died of choleric diarrhoea"[42] and a couple of weeks after that Dhavee "died of chronic dysentery".[43] The attention to detail in these examples, recording different verdicts on what must after all have been similar ways of dying, is worth noting as are examples such as the following.

> Kem Kurun. 50. Hindu. Labourer. 8 July 1869. Certified by the Magistrate violent.
>
> 8th July 1869. Sent in by the Depy. Commr. of Oonao in a very weak state.
>
> 20th July. Died of chronic diarrhoea.[44]

The only opinion arrived at by the medical officer is of this patient's physical condition and the only medical detail recorded is the cause of death. Significantly the column at the top left of the page, where the diagnosed mental condition is usually found, is empty and the only information about the man's behaviour which might be linked to his mental state is supplied by a civil rather than a medical officer. While it can be argued that this patient was alive for less than a fortnight in the custody of the asylum which was too little time for the medical officer to form an opinion on his mental state no such explanation can be offered for the example below.

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[38]Case Book II, patient no.172, admitted 27 April 1865.
[39]Case Book II, patient no.147, admitted 5 January 1865.
[40]Case Book II, patient no.143, admitted 17 December 1864.
[41]Case Book II, patient no.1, admitted 8 January 1863.
[42]Case Book II, patient no.12, admitted 23 March 1863.
[43]Case Book II, patient no.14, admitted 10 April 1863.
[44]Case Book IV, patient no.85, admitted 8 July 1869.

Gokul. Dementia. m. 18. Brahm. Cultivator. 17 Nov/64

17th Novr 1864. Sent in by Deputy Commr of Oonao.

29th Septr 1865. Died of chronic dysentery.[45]

While a diagnosis does exist there is no information about the basis for that verdict and the only medical detail in the document of a man who has been incarcerated for almost a year because of his supposed mental state is the cause of his physical demise. Quite simply then, the case notes are dominated by information on the patient's body rather than on his/her mental state and this is reflected in the insistence of the medical officer compiling the note on entering details surrounding the circumstances of death of the patient.

There are colonial and medical discursive circumstances in which this privileging of physical data is readily intelligible. The most obvious point to make is that the asylum superintendent was no specialist in mental illness in this period in British India, the author of the Bengal asylum report of 1877 stating readily that "few medical officers have had the opportunity of studying insanity".[46] This comes across in the correspondence between the Government of Madras and the Government of India in 1868/9 in which the arrangements for the new asylum at Madras were being debated. The Madras President protested that

> the classification of the insane, the regulation of their common social life under the cottage system, their recreation, their education, their cure, their employment in various descriptions of appropriate labour, all the processes of benevolence and science have to be studied and carried into effect. I do not see how this novel and multifarious duty can be performed here, except by the undivided attention of a medical officer who has bestowed a particular study on the subject.[47]

This was a point that he was reiterating as earlier the Government of India had disagreed with him that the medical officer needed to be "specially chosen for the duty".[48] The trouble was that the usual practice was simply to appoint the Civil Surgeon for the station as the superintendent of the local asylum.

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[45]Case Book II, patient no.139, admitted 17 November 1864.
[46]*Asylums in Bengal for the Year 1877*, p33.
[47]Minute by Pres.Madras, 29 October 1868, GOI (Public) Procs Feb 27 1869, 105-107A.
[48]Chief Sec.Gvt.Mad. to GOI, 26 November 1867, GOI (Public) Procs Feb 15 1868, 96A.

> The Medical Officer and Superintendent of the Asylum is the Civil Surgeon of the Station, and has to attend to the Dispensaries, Police and Lock-hospital and other duties pertaining to his appointment.[49]

As such he was unlikely to have any special training in dealing with those deemed to be insane, as was occasionally observed by non-medical officers, "the Chief Commissioner believes that in India the study and treatment of insanity has not attained the dignity of a *speciality* and that insanes are pretty much left to the care of nature".[50] Indeed there was no reason why the medical officer should have had any special knowledge. For example, the examinations to enter the Indian Medical Service certainly did not require any evidence of work in the field of psycho-medicine: "the examination covered surgery, medicine (including diseases of women and children), pharmacy, hygiene, anatomy, physiology, botany and zoology". [51]

In other words, the Civil Surgeon who found himself charged with the superintendence of the local asylum was trained as a physician and a surgeon, not a psychiatrist. His field of expertise was the body and its workings and his day-to-day business in running the dispensaries, lock hospitals etc. would require him to routinely observe, record and treat features of the body. This goes some way to explaining why the asylum case notes are often simply records of physical symptoms: all the superintendent was trained to do was to observe the body and so when confronted in a medical institution with a group of patients he would naturally fall back on what he knew best and most about and get on with the job of observing and recording the bodies of those patients.[52]

There is evidence however that many Indian medical officers took the trouble to read up on mental health theory or at least recalled bits and pieces that they had encountered in medical journals, reference books etc. Journals like the *Indian Medical Gazette* carried articles on insanity and reviews of the latest literature in Europe on matters relating to the insane through which medical personnel in India might have had access

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[49]Off.Super.Bareilly.LA to IGP.NWP, 21 May 1868, GOI (Public) Procs Dec 19 1868, 49A.

[50]*Asylums in the Central Provinces for the Year 1875*, p2.

[51]M.Harrison, *Public Health in British India: Anglo-Indian preventive medicine 1859-1914*, (Cambridge University Press 1994), p19.

[52]For nineteenth-century relationships between the body of the patient and the medical practitioner through the 'anatamo-clinical gaze' see M.Foucault, *The Birth of the Clinic: an archaeology of medical perception* (New York Vintage Books 1973), pp.121-126; P.Major-Poetzl, *Michel Foucault's Archaeology of Western Culture: toward a new science of history* (University of North Carolina Press 1983), pp144-146; D.Armstrong, 'Bodies of Knowledge/Knowledge of Bodies', in C.Jones and R.Porter, *Reassessing Foucault: power, medicine and the body* (Routledge London 1994), pp17-27.

to such information.[53] So for instance, Dr. Wise in the Dacca asylum report of 1872 feels fit to cite "Sir Charles Hood, in his 'Statistics of Insanity' [who] states that in 33.2 per cent of the admissions into Bethlem between 1846-1855, no cause for the madness was ascertained".[54] He uses this evidence to conclude that "there is little wonder, therefore, that in Bengal we find it extremely difficult to indicate the cause which in each case excites or predisposes to insanity".[55] The Inspector General of the Indian Medical Department in Bengal quotes Dr. Thurnam[56] as "a writer on the statistics of insanity"[57] in 1872 when discussing rate of recovery amongst asylum patients and a subsequent Inspector General has evidently consulted the findings of the *Lancet Commission on Lunatic Asylums* as he quotes directly from their report to show that "only a small proportion can be considered susceptible of cure or radical improvement".[58] The *Lancet* is apparently not the only source consulted by those involved in asylum administration as Surgeon-Major Payne who was the superintendent of the Dullunda asylum, in discussing the issue of non-restraint in the Report for 1873 decides to "confine myself to transcribing from the pages of the British Medical Journal (November 11th 1873) a brief summary of advancing opinion in Europe on the question".[59] In this passage references are made to a number of other sources, the *Edinburgh Medical Journal*, *Allgemeine Zeits Chrift*, *Annales Medico-Psychologiques*, so Payne is demonstrating a keen interest in up to date discussions of the problems of asylum management.

With this evidence of superintendents in many cases taking a keen interest in the medical theories of the day concerning their charges in the lunatic asylums it is possible to discern discursive circumstances in which the emphasis on physical information in the case notes can be understood. Consider the following account given by Dr. Nanney at the Madras asylum in his report for 1878/9.

> In Form 7 are detailed the various causes to which insanity is ascribed. These are divided into physical and moral. It must however be remembered that these divisions are merely arbitrary. The recognition of insanity as a purely physical disease is now gaining ground more surely and

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[53]For example, the review of J.Balfour-Browne, 'The Medical Jurisprudence of Insanity', in *Indian Medical Gazette*, vol.VIII, 1873, pp135-6.
[54]*Asylums in Bengal for the Year 1872*, p65.
[55]*Ibid*, p65.
[56]He is referring to John Thurnam, *Observations and Essays on the Statistics of Insanity*, (London 1845).
[57]*Asylums in Bengal for the Year 1870*, p7.
[58]*Asylums in Bengal for the Year 1876*, p4.
[59]*Asylums in Bengal for the Year 1873*, pp25-6.

> it must not be forgotten that the so-called cause is at most an exciting fact, or more probably merely the occasion on which the lurking disorder becomes outwardly manifest.[60]

Dr. Nanney is certainly one of the better informed of the superintendents in India, quoting such authorities as John Connolly[61] referring to "the infirmly sensitive mind bending under the weight of unexpected and sudden trial"[62] in the same Report as the one in which he makes the above conclusion. Indeed he demonstrates himself more than schooled in the nineteenth century's body of thought on mental health issues elsewhere[63] mentioning the work of Henry Maudsley,[64] Andrew Duncan,[65] Andrew Wynter[66] and John Charles Bucknill.[67]

What Nanney is insisting on here is an idea that is familiar from studies done of the theories of insanity in Europe in the second half of the nineteenth century. Laurence Ray, in looking at the development of Victorian psychiatry before 1860, concludes that "insanity was now seen to have a physical basis"[68] and more specifically that "psychiatric theory regarded insanity as physiologically based in brain pathology".[69] Andrew Scull agrees with this pointing to the "notion that insanity was caused by organic lesions of the brain"[70] and quoting doctors from the time insisting on

> the physiological principle ... that mental health is dependent upon the due nutrition, stimulation and repose of the brain; that is, upon the conditions of exhaustion and reparation of its nerve substance being maintained in a healthy and regular state; and that mental disease results from the interruption or disturbance of these conditions.[71]

This would certainly explain the details included in the annual reports in India of the appearance of the brain after a post mortem examination, as it was believed that if

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[60] *Asylums in the Madras Presidency during the Year 1878-9*, p12.
[61] Author of, for example, *The Treatment of the Insane without Mechanical Restraints*, (London 1856).
[62] *Asylums in the Madras Presidency during the Year 1878-9*, p14.
[63] *Asylums in the Madras Presidency during the Year 1877-78*, pp15-18.
[64] Described as, "probably the outstanding philosopher-psychiatrist of the 19th century" by Henry Rollin, 'Whatever happened to Henry Maudsley?', in G.Berrios and H.Freeman (eds.), *150 Years of British Psychiatry 1841-1991* (Gaskell London 1991), p351.
[65] Author of, for example, *Observations on the Structure of Hospitals for the Treatment of Lunatics as a Branch of Medical Police*, (Edinburgh 1809).
[66] Author of, for example, *The Borderlands of Insanity*, (London 1875).
[67] Author with Daniel Tuke of, for example, *A Manual of Psychological Medicine*, (London 1874).
[68] L.Ray, 'Models of Madness in Victorian asylum practice', in *Archives Européennes de Sociologie*, 22 1981, p243.
[69] Ibid., p241.
[70] A.Scull, *Museums of Madness: the social organization of insanity in Nineteenth-century England* (Penguin Middlesex 1982), p167.
[71] Ibid., p167. This is a quote from Bucknill and Tuke, *A Manual of Psychological Medicine*.

examined thoroughly enough the lesion of the brain, that is the actual alteration of the brain structure, would be visible:

> Luchman an old man, aged about 60 years, who died from epilepsy, had been in the asylum since its establishment in 1864, having been transferred from the old Nagpur Jail. The bones of his skull were much thickened, membranes thickened, and brain atrophied, besides which he had a fatty and enlarged heart.
>
> Sukaram, in the asylum since 1868, bed ridden for years, remained in hospital from the end of 1879, and died in November from peritonitis. His knees were contracted but there was no other sign of rheumatism. Heart small and pale, but free from adhesion or disease. Brain soft, pale and anæmic, membranes anæmic and not adherent.[72]

Andrew Scull notes a similar dedication to dissecting the brain in England in this period, and points out that even where it was difficult to discern any physiological alteration it was assumed that it was the techniques of post-mortem investigation that were wanting rather than the physicalist assumptions themselves.[73] Again, this adherence to the physicalist theory despite failure to find empirical evidence is a feature of discussions of the issue in India: "It is true that in cases which in life presented marked symptoms of mental aberration, the nature of a brain organic lesion, if present, eludes us; this should scarcely be subject for wonder while we are as yet unable to tell from looking at a brain the bent of the living man's intellect- cannot distinguish the brain of a great painter or poet from that of a mathematician. The conjecture is a fair one, that alike in both cases there may be differences in mechanism or organization which escape our present means of observation".[74]

German Berrios has shown how this conviction that mental illness had its origins in the physical state of the brain would have resulted in the recording on a case note of all manner of physical information relating, not so much to the brain, as to the rest of the body. He points to

> the analytical and correlational epistemology of the anatomo-clinical view of disease [which] demanded the identification of surface markers, of signs of disease which could represent the anatomical lesion ... The early stages of this process were carefree but soon longitudinal observation, biological markers and statistics introduced a sense of discipline and order.[75]

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[72] *Asylums in the Central Provinces for the Year 1880*, p3.

[73] A.Scull, *The Asylum as Utopia: W.A.F.Browne and the mid-Nineteenth century consolidation of Psychiatry* (Routledge London 1991), intro.pxxix.

[74] *Indian Medical Gazette* review, vol.VIII, 1873, p135.

[75] G.Berrios, 'Obsessional disorders during the nineteenth century: terminological and classificatory issues', in W.Bynum, R.Porter and M.Shepherd, *The Anatomy of Madness: essays in the History of Psychiatry*, (Tavistock London 1985), p167.

and more recently again emphasised this, stating that, "a salient difference between pre and post 1900 descriptive psychopathology is that physical (somatic) signs played a far more important role in the former".[76] He lists such physical symptoms as headaches, tremors, pallor, blushing and changes in bowel or urinary habits and concludes that "the latter were considered as primary features and as directly related to brain pathology as the typical manifestations of mental disorder".[77]

Andrew Scull has attempted to relate this knowledge to the power relations of the period. He points to the fact that the medical profession's insistence that mental illness was a matter of physiological disruption served their purposes as an interest group. He identifies three tasks among members of the medical profession in the first half of the nineteenth century:

> Persuading those with power in the political arena of the horrors of the traditional and still flourishing madhouse system and thus of the urgency of reform; establishing asylums run on the new system of moral treatment as the solution to the problem of providing care and treatment for the insane; and reasserting and establishing on a more secure foundation medicine's threatened jurisdiction over madness.[78]

Central to the last part of this project was the development of a fully thought out intellectual rationale for legitimately claiming that madness ought to be the exclusive preserve of those who were medically trained as opposed to being the concern of, for example, those with religious training. Scull directly links the assertion that "the brain, as a material organ was liable to irritation and inflammation and it was this which produced insanity"[79] to this last part of the project, in other words the physicalist discourses on mental illness were a product of the quest for legitimacy on the part of the medical profession during the nineteenth century.

The nature of the information that is included on the case notes from the Lucknow lunatic asylum can be linked to a number of medical discourses then, from discourses of medical legitimacy to the anatomo-clinical gaze. Yet the fact that the asylums operated in a colonial setting adds resonance to the existence of so much physiological information in the case notes. In other words there are discourses other than those which can be traced to the medical realm which formed the circumstances in which the knowledge in the records was produced.

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[76]G.Berrios, *The History of Mental Symptoms: descriptive psychopathology since the nineteenth-century*, (Cambridge University Press 1996), p21.
[77]Ibid.
[78]A.Scull, *The Asylum as Utopia*, intro.pxxiv.
[79]Ibid., pxxx.

David Spurr for example identifies the body of the colonised as a crucial element in the discourses of Empire:

> In classical colonial discourse, the body of the primitive becomes as much the object of examination, commentary and valorization as the landscape of the primitive. Under Western eyes, the body is that which is most proper to the primitive, the sign by which the primitive is represented. The body, rather than speech, law or history, is the essential defining characteristic of primitive peoples.
>
> The bodies, not only of so-called primitive peoples but of all colonized, have been a focal point of colonialist interest which, as in the case of landscape description, proceeds from the visual to various kinds of valorization: the material value of the body as labour supply, its aesthetic value as a mark of innocence or degradation, its scientific value as evidence of racial difference or inferiority, its humanitarian value as the sign of suffering, its erotic value as the object of desire.[80]

One example of the process Spurr describes whereby the body of a people is assumed to represent the character of that people is the Indian experience in which the Indian body was feminised in the British imagination and equated with the characteristics, potentialities and the fate of the colonised Indians. Ashis Nandy has suggested that "the decomposition of the human body was seen as only an indicator of the evil in the one degenerating ... it was this postulate which came to the fore in Europe's new ideology of male adulthood, completing the picture of a world where only the adult male reflected a reasonable approximation of a perfect human being".[81] This resulted in an ethos of 'hyper-masculinity' coming to dominate the cultures of the colonisers. The reverse side of this was that the Indian was essentialized as the Other of the hyper-masculine and so there are constructions like that of "the effeminate Bengali"[82] reflected in the works of such colonisers as Thomas Babbington Macaulay:

> The physical organization of the Bengalee is feeble even to effeminacy. He lives in a constant vapour bath. His pursuits are sedentary, his limbs delicate, his movements languid. During many ages he has been trampled upon by men of bolder and more hardy breeds. Courage, independence, veracity are qualities to which his constitution and his situation are equally unfavourable.[83]

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[80]D.Spurr, *The Rhetoric of Empire: colonial discourse in journalism, travel writing and imperial administration,* (Duke University Press London 1993), p22.

[81]A.Nandy, *The Intimate Enemy: loss and recovery of self under colonialism*, (Oxford University Press 1983), p16.

[82]M.Sinha, *Colonial Masculinity: the 'manly Englishman' and the 'effeminate Bengali' in the late nineteenth-century* (Manchester University Press1995), p11.

[83]Macaulay quoted in ibid., pp15-16.

Quite simply, the body of the Indian here is taken as representative of the Indian's entire self, its perceived weakness being taken as indicative of the perceived moral deficiencies of the Bengalee spirit.

India also provides excellent examples of the process that Spurr describes whereby the body becomes a focal point of colonial interest. David Arnold looks at the functioning of the Indian Medical Service during episodes of epidemic disease and concludes that "over the long period of British rule in India, the accumulation of medical knowledge about the body contributed to the political evolution and ideological articulation of the colonial system".[84] In other words medical surveillance was central to the techniques by which the coloniser watched the body of the colonised and produced knowledge about the corporal site. It is in this context that the attention to the physiological on the case notes of the Lucknow lunatic asylum must also be understood. Colonial medical officers were key actors in the role of studying the Indian body, a process readily engaged in as colonial culture imagined that by examining the bodies of the Indians that arrived in the asylum they were studying that which was most appropriate for understanding the Indian.

By making these links then it can be seen that the amount of physical information on the case note reflects more than the medical officer's inexperience in dealing with mental illness and the spatial focus of the anatamo-clinical gaze of modern medicine. The physiological observations connect the information on the case notes to colonial as well as to medical power relations. The conviction that the body was the correct site for knowing the Indian is related to representations of the colonised as the Other of the coloniser which underwrote colonial domination. The concern to gather information about the Indian body reflects the attempts of the colonial authorities to govern through knowledge of the Indian body.

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[84]D.Arnold, *Colonizing the Body: state medicine and epidemic disease in nineteenth-century India*, (Oxford University Press 1993), p8.

Despite the amounts of physical information included on the case notes there *are* references to the behavioural state of the patient and the responses of the patient to the therapy available in the asylum.

Heengun Khan. Mania. Mussulman. Cultivator. 26. 30th April 1860.

> Sept, 60. An inhabitant of Moosalbagh. Is said to have been subject to fits of insanity for 12 or 14 years. During intervals has been able to work. Is of a very restless disposition + much taken up with his personal appearance, decorating himself with whatever in the shape of supposed finery falls in his way, not despising as a necklace and old leather Doomchee. Is occasionally violent + continually begs for release. General health and appetite good.
>
> Oct.24. For the last month has been generally quiet + well conducted, working hard in the garden + greatly pleased at receiving commendation or trifling rewards. Today became unaccountably violent, had to be confined- blister applied.
>
> March 1861. For the last three months, there has been a steady improvement in this patient. He takes his meals well + has done bheestie's work very steadily. For the last month his demeanour has so much improved that on his relatives coming to enquire after him I discharged him on the 24th March, cured.[85]

The case note for Heegun Khan reads as a heartening story of improvement as he recovers sufficiently from being fitful and violent to be released to his relatives. Yet look again at the type of information recorded which is in the case note to indicate illness and recovery. Illness is violence and self-absorption. Recovery is obsequious obedience and the desire or ability to work steadily. Pick out the adverbs of illness and recovery, 'unaccountably' as opposed to 'steadily'. The issue to be considered here is whether the privileging of the ability to work and to be governable (because obedient and steady) over the need to be expressive of fluctuating inner desires and feelings (which are unpredictable and sometimes violent) is necessarily a natural correspondence to the privileged state of mentally healthy over mentally ill.

The work of feminist scholars is important here as they are keen to remind that asylum regimes in Europe were not concerned with restoring a natural state of mental health when it came to female patients. Yannick Ripa insists that "the asylum sought to force women back into the mould from which they had just tried to escape",[86] and that in France in the nineteenth-century

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[85]Case Book IA, patient no.13, admitted 30 April 1860.

[86]Y.Ripa, *Women and Madness: the incarceration of women in nineteenth-century France*, (Polity Press Cambridge 1990), p160.

> to be cured meant to be passive and submissive. The image of healthy womanhood put forward by the special doctors, those products and exponents of bourgeois society, was of silent women who showed moderation in everything, and who sublimated all their own desires in their role as mothers.[87]

Elaine Showalter finds this to be similar to the experience in England in the same period as "the ladylike values of silence, decorum, taste, service, piety and gratitude ... were made an integral part of the program of moral management of women in Victorian asylums".[88] It was not just in the lunatic asylum that 'recovery' was linked to imposed norms. Joanne Monk examines the Magdalen asylum in Australia which was opened and operated for the reform of 'fallen women' in the 1880s. In it she finds that the regime centred around the performance of laundry duty. Laundry duty was specially chosen as it was seen as an essentially female task and that therefore the correct performance of this task was supposed to signify 'reform', or rather return to the desired norm of domesticated femininity.[89] Reform or recovery in women was very much judged in these institutions not by reference to some natural standard of health and illness but by reference to a standard of behaviour derived from the social and cultural discourses of patriarchy.

With the idea that recovery from mental illness could, in certain circumstances, be a judgement on an individual's compliance with certain prescribed ways of behaving, and recent research into the desires and objectives of the coloniser regarding the colonised, the case note from the Lucknow lunatic asylum included above appears to be rather more than a simple record of the patient's behaviour. Neither was such a case note untypical:

> Ramcharum. Acute mania. 25. Hindoo. Beggar. 11th May 1870.
> Certified by the Magistrate violent.
>
> 11th May. Sent in by the Depy.Commr.of Oonao. It appears to be a case of mania from excessive bhung smoking.
>
> April 4th 1874. For several months Ramchuram has seemed to be in his right mind. He has been useful in helping to cook for the other patients. To be brought before the Committee.
>
> 7th April 1874. Cured, made over to his friends by order of his friends.[90]

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[87]Y.Ripa, *Women and Madness*, p161.
[88]E.Showalter, *The Female Malady: women, madness and English culture, 1830-1980*, (Virago London 1987), p79.
[89]J.Monk, 'Cleansing their Souls: laundries in institutions for fallen women', in *Lilith*, 9, 1996, pp.21-31.
[90]Case Book IV, patient no.192, admitted 11 May 1870.

This case note from towards the end of the period for which case notes are available records the direct relationship between the ability to work and the assessment of recovery as the only information included to justify the statement that he seems to be in his right mind is that he is now able to labour and is useful. Indeed the doctor who composed the following example from the second volume of case notes seems to acknowledge that when he had to comment on whether somebody was mentally 'well' he was actually looking for certain characteristics.

> Wazeeran. f. Mania. 28. Mussul. Beggar. 15 Jany/63
>
> 1863. Sent in by City Magistrate found knocking about the City, is very violent and wild in manner and expression.
>
> 1868 May 5. This woman has been five years in the asylum. She seems to be well, at least she works + does what she is told + gives intelligent answers to questions + is quiet, eats and drinks + sleeps properly.
>
> She says she is a prostitute + will return to the exercise of her profession if released.
>
> May 11. Discharged.[91]

He seems to imply, in qualifying his assessment that she is 'well', that the criteria for being judged 'well' was not an esoteric series of standards regarding proper perceptual relations between the inner life and the outer world but merely the requirements he lists, in other words he is saying that he would not put his name to a judgement that she is absolutely 'well' but rather that she is considered 'well' as she appears to be socially functional. The criteria for 'socially functional' were productivity, obedience, intelligibility and self-regulation. There were distinct cultural reasons why it was these characteristics which formed those criteria.

Nikolas Rose gives an account of *political economy* as an understanding of the universe in Europe which developed throughout the nineteenth century, in which the self-regulating mechanisms of the economy operated in a benign way to produce a wealthy and well-organised society.[92] It followed from this belief that those who chose not to engage in the economic system, typically those who refused to sell their labour, were therefore flouting the natural and beneficent mechanisms. Such people became the focus of asylums and workhouses, as a belief in the essential morality of man had encouraged the idea that such people were in need of reform as within them

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[91]Case Book II, patient no.2, admitted 15 January 1863.

[92]N.Rose, *The psychological complex: psychology, politics and society in England, 1869-1939*, (Routledge London 1985), p45.

existed the essence of a moral (industriousness, compliance, deference, modesty[93]) person which simply needed encouragement.

These were ethics which were certainly powerful in India by the 1860s: "The qualities that were most prized were efficiency, practicality, conformity".[94] The system of land reform which had come to dominate by the 1840s envisaged that

> the result would be the same as everywhere else where the magical influence of property rights was allowed its natural field of operation- namely, economic prosperity and moral improvement as cultivators found themselves surrounded by a socio-economic environment that rewarded hard work, thriftiness, and a desire to get ahead.[95]

This enthusiasm for political economy and the corresponding enthusiasm for the virtues connected with work, "the best riches are the effects of a man's own industry"[96] said James Mill while discussing his plans for India in the House of Commons, explains why the ability to labour in an Indian lunatic patient would have so impressed itself on an observing British medical officer that he included the fact in a case note. The culture of political economy dictated that industry was good, indeed natural, so the sign of a previously disruptive individual beginning to work would have been interpreted in this cultural frame of references as a 'recovery' of the natural state.

Yet any account of an Indian being transformed from a state 'wild of manner or expression' involving violence or narcissistic self-contemplation to a new state of industriousness and usefulness has added resonance because of the colonial context. The colonisers' imagination was dominated by fantasies of what India was and what it ought to be. Remember, the Utilitarian writers who focused on India in the 1830s but whose influence was being felt by the 1860s[97] thought that principles of political economy were not just to be safeguarded or upheld in India, but rather they would have to be introduced and for this to happen there would have to be an extensive reform of Indian society. After all they believed "in short that, despotism and priestcraft taken together, the Hindus, in mind and body, were the most enslaved portion of the human race".[98] Other Orientalist images of the Indian abounded in the

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[93]N.Rose, *The psychological complex*, p26.
[94]M.MacMillan, 'Anglo-Indians and the Civilizing Mission 1880-1914', in G.Krishna, *Contributions to South Asian Studies 2*, (Oxford University Press 1982), p73.
[95]L.Zastoupil, *John Stuart Mill and India*, (Stanford University Press 1994), pp135-6.
[96]Quoted in E.Stokes, *The English Utilitarians and India*, (Oxford University Press 1959), p64.
[97]J.Majeed, *Ungoverned Imaginings: James Mill's 'History of British India' and Orientalism*, (Clarendon Press Oxford 1992), p194.
[98]James Mill, *The History of British India*, vol.II (London 1858), p167.

colonial imagination. Ronald Inden points out that the Indian mentality was constructed as the opposite of the Western one so that when thinking of the Indian mind:

> That mind is ... governed by passions rather than will, pulled this way and that by its desire for glory, opulence, and erotic pleasures or total renunciation rather than prompted to build a prosperous economy and orderly state. The Indian mind is, in other words, devoid of 'higher', that is, scientific rationality.[99]

When the experiences of 1857 were linked to such ideas it seemed obvious that the Indian would, by nature of the domination of the passions over the mind, be thought of as violent and unpredictable. Anglo-Indian literature of the period made these connections, as Susanne Howe notes: "Everything in India was alien, mysterious, hostile in a thousand complex, unfair, ways".[100]

The British saw India as irrational, unpredictable, spiritual, sensual, violent. But as work on the moral philosophy of Empire confirms, it was exactly this image which encouraged the British belief that their role in India was necessary: "It is the supposed absence of these assumed attributes of Western culture- such as advanced rationality, individual discipline, and social habits of obedience- that mark the Indians as childlike creatures in need of paternal oversight".[101] As has been said, many of the colonizers desired not simply to protect but to reform Indian society and culture, it was decided that, "it was more important to civilize than subdue" and it was intended that, "the whole of Indian society would undergo a vast transformation, setting it on a rapid advance up the scale of civilization".[102] In other words the British fantasised that they would transform India from 'uncivilized', that is unstable and unintelligible to 'civilized', that is ordered, industrious and regular.

> Mukhsoodally Khan. m. amentia. mussul. service. 25. 8 June/61
>
> 1861 June. This man was formerly a sowar in the 1st Regt. of Hodson's Horse at Fyzabad. Was admitted into Regl. Hospital on 14th May on account of mania- cause not apparent- He was noisy, violent + abusive, bit himself on legs + arms + required the constant supervision of attendance to prevent his escaping or injuring himself. Subsequently he had an attack of fever. On admission he was very excitable and talked very unnaturally and abusively.
>
> 1862 Feb. In several months past this man has improved in health, has been quiet + well conducted and assisted in the garden. He is stout + strong. All bodily functions properly

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[99]R.Inden, *Imagining India*, (Basil Blackwell Oxford 1990), p264.
[100]S.Howe, *Novels of Empire*, (Kraus New York 1971), p33.
[101]L.Zastoupil, *John Stuart Mill and India*, p175.
[102]E.Stokes, *The English Utilitarians and India*, pp43-56.

> performed + he does not appear to be labouring under any delusion. His relatives are anxious to remove him + I therefore, as he has been well for months, discharge him cured.[103]

Mukhsoodally Khan undergoes this transformation according to the case note. Violent, unintelligible ('talked very unnaturally') and unpredictable ('cause not apparent') he becomes regulated ('all bodily functions properly performed'), respectful and works well. His case note reads as a fantasy of the colonial project where the Indian Other of the rational European is civilized through the benign intervention of the West. The information included on the document is not the result of impassive and objective surveillance of the individual in question, but rather the product of the imaginings and expectations of a British medical officer during the period of 'high colonialism'. The fact that the medical officer in question is looking at a supposedly insane rather than a sane Indian is of no consequence as he would have had one set of conceptual references with which to see all Indians, or as Megan Vaughan points out when considering psychiatry in another colonial context:

> To put it simply, whilst the history of insanity in Europe is the history of the definition of the mad as 'Other', in colonial Africa the 'Other' already existed in the form of the colonial subject, the African.[104]

Discourse and the case-note.

It would be foolish to assert that all the case notes were composed just after the medical officer in charge had finished flicking through the latest edition of a Utilitarian tract, or for that matter a recent issue of the *Lancet* or a treasured copy of *A Manual of Psychological Medicine*. What can be said though is that some of the discursive circumstances of the case notes can be recovered, although it must be stressed that 'physicalist interpretations of mental disease' or 'Orientalist constructions of the Indian' were not the only discourses which influence the nature of the information noted on a case record. Consider the information included between the states of illness and recovery on Phoola's case note.

Phoola. f. mania. brahmin. cultivator. 35. 1st February 1861

> 1861 Feb. Was sent in from Sultanpore along with Ramdeen. This is said to be her second attack of insanity. Previous to her admission here she had been treated for a month in the Jail Hospital at Sultanpore. This present attack is attributable to fever. Was never subject to

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[103]Case Book IA, patient no.114, admitted 8 June 1861.

[104]M.Vaughan, *Curing their Ills: colonial power and African Illness*, (Polity Press Oxford 1991), p101.

epilepsy. On admission looked very wild, talked incessantly with a loud + very harsh voice. Was very violent + excited. Beat + abused other lunatics- did not sleep, refused food.

April. The violence of her symptoms have a good deal subsided. She occasionally smiles + cries apparently without cause- took a great fancy to a newly born infant whose mother a lunatic, would not look at it. Kept it continually on her knee + finally put it to her own breast, whence in three or four days milk actually flowed. The infant however was premature + could not subsist on insufficient nourishment and died, much to the grief of Phoola.

July. This woman has steadily improved. She talks sensibly and acts normally. Discharged cured.[105]

If the observations of Yannick Ripa on male perceptions of the female social role, which were included earlier, are recalled then it is plain that the knowledge of Phoola presented in the case note was produced within a gendered discourse of correct behaviour. The comment that Hoolass "is only one of many of our old sepoys who have gone mad since 1857"[106] suggests another element of Anglo-Indian colonial discourse at work in deciding what information was included on a case note.[107] In other words there is no over-arching or dominant discourse operating to determine the content of the individual asylum records but rather there was a whole complex of discourses in which the case note was produced.

CONCLUSION.

The claim of medical documents is that they are materials which contain objective information on naturally occurring phenomena. Those who subscribe to this take the information contained in those documents at face value, compile statistics from them and where they consider it necessary translate the information they believe they have revealed in the old categories into contemporary ones. These are the projects of counting and retrospective diagnosis.

The problems with such projects have been demonstrated to be numerous. Even the simplest of data like that on age can be doubted for its accuracy so basic exercises like demographic profiling of patient population can be accused of doing no more than reproducing the mistakes of the past. More complex data such as that on the

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[105]Case Book IA, patient no.81, admitted 1 February 1861.

[106]Case Book IV, patient no.107, admitted 22 August 1869.

[107]The belief that the widespread armed resistance to British rule in Northern India (and Lucknow from where the case note comes from was a centre of discontent) in 1857-8 was no more than a sepoy rebellion was a popular one amongst the British in the period after the rebellion as it justified continued presence in India. See E.Stokes, *The Peasant Armed: the Indian Revolt of 1857*, (Clarendon Oxford 1986), p4.

quintessential medical procedure of diagnosis is similarly questionable, as it is difficult to establish that diagnostic labels remained stable between geographic and temporal locations and therefore conclude authoritatively that all the people said to be suffering from one disease did indeed all have the same symptoms. Indeed, as has been shown, the whole concept of symptoms of mental disease is problematic in this period, as the information included on the case notes in Lucknow has been demonstrated to be less a series of objective observations of a naturally occurring condition and more a collection of statements which reflect ideas of social and moral fitness and the operation of certain culturally specific modes of observing. These discourses, of the medical gaze, of the significance of the Other's body, of the possibility of reforming the Indian mentality, of gendered norms of behaviour are all linked to power relations in the period, to the rise of the medical profession, to the colonial order, to the desires of the bourgeois male and so on. By tracing them it is possible to identify a number of the ways that the British saw themselves and Indians in the colonial relationship.

In British India then it is difficult to disagree that

> patient records are surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed.[108]

For this reason the historian may legitimately use sources like the asylum records of British India to trace the relationship between power and knowledge but the researcher must be wary of looking at the records in the hope of using them to explore the epidemiology of the past.

In other words, the records of the lunatic asylum provide compelling evidence of power relations in the colonial context as the details of supposedly scientific documents like a psychiatric case note turn out to be a series of representations and judgements of the Indian which in many instances were born of and which served colonial domination. They fail, however, to provide much evidence of the mental states of the Indians of which they are supposed to be a record but in reflecting the way that the British saw and looked at Indians it might be considered an irony that documents at the asylum like the case notes offer an insight into the mental states of the British colonisers who wrote them.

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[108]G.Risse + J.Warner, 'Reconstructing Clinical Activities: patient records and medical history', in *Social History of Medicine* 5, 1992, p189.

CHAPTER II.

The Phantom Cannabis User: the lunatic asylum and productive knowledge.

CHAPTER II. THE PHANTOM CANNABIS USER: THE LUNATIC ASYLUM AND PRODUCTIVE KNOWLEDGE.

ASSAULTS BY GANJA SMOKERS.

> Murderous assaults by individuals under the influence of Indian hemp have been somewhat frequent of late in Bombay. At the Bombay Police Court, towards the end of May last, two cases of this nature came up for trial ... In the one case the prisoner Khuda Baksh, without provocation struck with his fists a Parsee child aged 2½ years which was being carried along the street by an older girl. He thereafterwards seized the child by the legs and dashed its head on the ground. He was then seized by the passers by and on being brought before the Magistrate pleaded guilty saying that he at the time was under the influence of ganja, and did not know what he was doing. As the child recovered from the concussion of the brain the man was only sentenced to six months vigorous imprisonment. In the second case a Moghul, named Syed Hossein Ali Khan, while under the influence of ganja was walking in the street with an open knife in his hand when he made a thrust at another Moghul with his knife. The attacked individual by stepping backwards received only a comparatively superficial wound over the stomach. The assailant then fled through the bazaar like a maniac brandishing the knife and threatening every one in his neighbourhood. He was seized with much difficulty and was sentenced to six months rigorous imprisonment. A very large number of inhabitants of this country are addicted to this form of intoxication and the present low price of the drug allows of its being too readily procurable so that further restrictions on its sale are certainly called for in order to lessen this source of bodily danger to which the public are constantly exposed.
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> ***Indian Medical Gazette*, editorial 1885.**[1]

Despite the fact that the British licensed sales of hemp derivatives and levied duty on those derivatives throughout the nineteenth century, those narcotic preparations and their consumers gradually took on negative associations in the colonial imagination as the century progressed. The above sensationalist account, taken from the *Indian Medical Gazette,* contains all the elements of the stereotype of the 'ganja-smoker' which appears with increasing frequency in British documents after 1857 and was the subject of Government of India enquiries in 1871 and 1891. He was murderous and unpredictable, lurked around in the bazaars and was indiscriminate in his rage.

Yet British attitudes had not always been negative towards hemp and hemp use and the positive effects of preparations of the plant were explored early on in the nineteenth century. Indeed attitudes towards the hemp user were not uniformly negative even in the 1870s when one British officer was moved to

> observe that I have not in my experience seen bad effects arising solely from the daily use of ganja or bhang, such as confirmed cases of insanity or a propensity to commit violent crimes;

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[1] *Indian Medical Gazette* 1885, Vol.XX, p220.

> on the contrary, I learn that the ganja-smokers and bhangees, as a rule, are very timid, retiring, and respectful, and that they do not like to be interfered with, nor do they interfere with others.[2]

Yet the enquiry launched in 1871 by the Government of India, to which the above officer was responding, had couched itself in terms of whether the hemp user was insane or murderous, in other words the very idiom of the enquiry indicated that he was under suspicion, and the result was that the colonial state elected to interfere with the ganja-smoker by advocating restrictions on the cultivation, preparation and retail of the drug and levying punitive duties on it.

This chapter will explore the way in which the ganja-smoker came to occupy this place of suspicion in the colonial imagination. While the discursive circumstances in which the distrust of the ganja-smoker can be understood will be looked at what is of prime concern here is the process by which the figure of the ganja-smoker became established and embellished in the colonial psyche. In other words the stages by which a vague wariness of hemp narcotics crystallized into the detailed spectre of the British imagination will be identified here.

The account given above in the *Indian Medical Gazette* is an ideal place to start any investigation into how the 'ganja smoker' or 'hemp user'[3] became a concern of the colonial state in this period. Rather than attach significance to the description in that account of the 'ganja-smoker' under the impression that it is a true representation of an external reality, other elements need to be emphasized. The account, about public order offences, appears in a *medical* journal rather than a police gazette or a judicial circular. This might appear incongruous at first but is in fact highly significant. Also, the author is keen to assert the validity of his argument by giving it statistical weight, making a mention of a couple of specific instances of breach of the peace indicative of

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[2]'Papers relating to the consumption of ganja and other drugs in India', in *British Parliamentary Papers* (Vol.66 1893-4), p42.

[3]In this investigation it will be assumed that ganja smoker, bhang drinker, hemp user etc. refer to the same figure in the colonial imagination, as the British while aware that there were a variety of preparations of the cannabis plant were usually content to treat them as one and the same. The different preparations that are mentioned are as follows: Ganja is the dried flower head of the Cannabis Sativa variation of the hemp plant which is smoked, mixed with tobacco often in a chillum (clay pipe). *Bhang* is the ground leaves and stalks of the Cannabis Sativa, mixed into a paste and drunk with milk and sugar or taken neat with black pepper. *Charas* is the dried, sticky exudation of the Sativa smoked with tobacco in a chillum. *Majum* is a green sweetmeat made with the ground leaves of the plant mixed with butter, milk and sugar and baked. *Muddat* is a preparation of hemp and opium.
This investigation will also refer to the 'ganja-smoker' as a 'he'. The vast majority of patients in lunatic asylums who it was thought went mad because of hemp use were male and in reports the 'ganja-smoker' was usually male: in other words the British conceived of the 'ganja-smoker' as male.

a wider phenomena by mentioning that 'a very large number of inhabitants of this country' are prone to just such an offence by virtue of their sharing a habit with the two cases he highlights.

Medicine and statistics, it is these two elements of the article in the *Gazette* and the potency of the two combined in the colonial encounter, which hold the key to an explanation of what the 'hemp user' was and how the asylum is central to any discussion of such a figure. It is argued here that the alarmist descriptions of a class of lurking drug fiends liable at any moment to madness and violence are not accurate descriptions of an actual gang of people in Indian society, but embellishments of an imaginary threat to public order whose characteristics were concocted through the ways of observing the Indian population at medical institutions like the lunatic asylum and which was established as a concern of the state through the information gathering and collating techniques of statistical mapping and analysis which were so integral a part of colonial government.

The Hemp-User in the Colonial Imagination.

Nikolas Rose in his work on the development of modern government and medicine in the nineteenth and twentieth centuries has identified a process he calls the "mapping of the population or at least its problematic sectors", a process in which "the psychological sciences had a role ... in providing the devices by which human capacities and mental processes could be turned into information about which calculations could be made".[4]

This process of mapping the population, rendering a mass of people into clearly defined groups each of which had specific qualities, characteristics and inter-relationships, for the sake of making them susceptible to organization and control is a familiar feature of colonial India, especially in the period after 1857.

> For the white colonials of the last decades of the nineteenth century, the Indian landscape is not teeming with the simple joys of diversity and variety, of God's plenty; rather it is a hazardous and threatening environment for the popular mind, an environment that needs to be tamed, controlled, at the very least mapped and understood.[5]

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[4]N.Rose, 'Calculable minds and manageable individuals' in *History of the Human Sciences*, Vol.1 no.2, 1988, p185.
[5]S.Mohanty, 'Kipling's Children and the Colour Line', in *Race and Class*, 31, 1, (1988), p30.

This project of mapping populations though is not simply a process by which identities and units 'out there' in the mass of people were observed and recorded. Rather, identities and units were created in the processes of observing and recording. A number of writers have identified the productive nature of these processes as an essential part of modern government, Ian Hacking was quoted in the introduction as concluding of the census that "the counting is no mere report of developments. It elaborately, often philanthropically, creates new ways for people to be",[6] and commentators summarizing the work of Michael Foucault state that

> to be able to name something is also to be able to position it within particular discursive arrangements, to literally 'put something in its place' and thereby determine what is to constitute adequate or proper knowledge of it. This is what Foucault means by power as creative: it brings objects into the realm of acceptable knowledge but does so in ways that render them knowable only in terms of that knowledge.[7]

With this in mind consider statements like that of the Commissioner of Orissa in 1872.

> The Commissioner has always looked on a ganja-smoker and a bad character as synonymous, and has, in his connection with lunatic asylums in different parts of Bengal, observed that in a large number of cases insanity has been induced by excessive ganja-smoking.[8]

By virtue of smoking a part of a plant an individual, in the eyes of the Commissioner, becomes implicated in an identity, and becomes bracketed as a human type rather than just an individual at a certain time and a certain place having a puff on a weed. The 'hemp user' or 'ganja-smoker' was a human type, a category in the taxonomy of human types in India with identifiable and unique characteristics which could be universalized to apply to all who fell into that category. As the Commissioner of Orissa says, that type was known as bad, and was associated with madness. It is the origins of that category, of that place on the map of Indian society drawn up by the British in their imaginations and their texts, which will be examined here.

As stated already, this is important as it was not just isolated officers out in Orissa or impressionable correspondents of the *Indian Medical Gazette* who knew what the

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[6]I.Hacking, 'Making Up People', in T.Heller, M.Sosna and D.Wellerby (eds.), *Reconstructing Individualism: autonomy, individuality and the self in Western thought* (Stanford University Press 1986), p223.

[7]B.Carter, 'Rejecting Truthful Identities: Foucault, 'race' and politics', in M.Lloyd and A.Thacker (eds.), *The Impact of Michael Foucault on the Social Sciences and Humanities*, (MacMillan London 1997), p129.

[8]*British Parliamentary Papers*, p78.

'hemp user' or 'ganja-smoker' was. In 1891 the figure of the 'hemp user' entered the House of Commons when Mark Stewart M.P. was moved

> to ask the Under-Secretary of State for India whether his attention has been called to the statement in the *Allahabad Pioneer* of the 10th May last that ganja 'which is grown, sold and excised under much the same conditions as opium', is far more harmful than opium, and that 'the lunatic asylums of India are filled with ganja smokers'.[9]

This prompted the second of the India-wide enquiries into 'ganja-smokers', the first of which had been initiated by the Government of India in 1871. The responses to this enquiry show that across India there were strong associations made with the 'ganja-smoker'. "Hushiarpur says that in March 1864 the Nehung Sikh who killed the Reverend Mr.Janviers (missionary) was a known bhang drinker"[10] asserted the Punjab authorities, while Hyderabad forwarded the opinion that "it is generally said, and I believe with much truth, that when a man 'runs amuck' or a female commits 'suttee' that before committing the act they are intoxicated by the use of hemp in some form or other".[11] Those in Berar were afraid that, "Bhang is also taken by immoral people as an 'aphrodisiac' as tending to excite the sexual passions. Preparations of hemp are also much used by women for the purpose of procuring abortion",[12] while an old medical officer in Burma was able to assert that "most of the acts of Mutiny of 1857 were undertaken under the influence of bhang, charas or ganja".[13] The hemp user in the colonial imagination was infanticidal, libidinous, self-destructive, the murderer of Christians, and even the typical 'Mutineer'.

Once established as a dangerous type in Indian society, the full force of Western science was focused on the 'known bhang-drinker'. So, for example there is a report in the *Lancet* in 1880 entitled 'Poisoning by Indian Hemp; Autopsy'.[14]

> The *Indian Medical Gazette* reports a case of death resulting from Indian hemp, some preparation of which the deceased had been accustomed to smoke for many years. After so indulging he generally became insensible or stupid. He was delirious for a fortnight before his death. On the day on which he died he tried to hammer a nail into his temple, and then expired suddenly ... beneath the dura mater blood was found effused over the whole upper surface of right brain and over the frontal lobe of left brain. A large clot was found in the right middle fossa of skull; this extended across the crux and pons ...

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[9] *British Parliamentary Papers*, p3.
[10] Ibid., p17.
[11] Ibid., p29.
[12] Ibid., p27.
[13] Ibid., p35.
[14] 'Poisoning by Indian Hemp: Autopsy', in *Lancet*, 10 April 1880, p585.

As well as cutting up the hemp user to find evidence of his rotten brain, science observed his body so that some distinguishing characteristics might be discerned by which the danger could be identified.

> Old Bhang drinkers, charas and ganja-smokers and majum-eaters are, as a rule, emaciated. They lose vital energy, become impotent, forgetful, weak-minded and melancholy ... again charas-smokers are often asthmatic. I can remember several where there was emphysema of both lungs; where, like broken-winded horses, they had ruptured the fine air cells of the lungs from long-continued and oft-repeated inspiration and expiration. Haemoptysis is not uncommon amongst them.[15]

Indians were observed, investigated and ultimately cut open as it was believed that they were hemp users, that is members of a class or type of human with its own potentialities and defining characteristics. The 'ganja-smoker' or 'hemp user' was an established figure in the imaginations of the British by the 1890s. Unpredictable, violent, lunatic, he stalked the bazaars and was liable to suddenly and uncontrollably threaten public order. He consequently became a concern of the colonial state. Yet the evidence suggests that this was only a phenomenon of the latter part of the nineteenth century and that the period before the 1860s was one in which there was considerable amibavelence amongst the British to the use, and users, of hemp narcotics in Indian society.

British attitudes to Hemp.

Throughout the nineteenth century it was understood that certain preparations of hemp were at the very least intoxicating. Whitelaw Ainslie, who compiled the first book length account of Indian medicines of the British colonial period, thus observed of Banghie that "this is an inebriating liquor, which is prepared with the leaves of the *ganjah* plant (*cannabis Indica*)".[16] The entry under Majum reads:

> These are the names of an electuary which is much used by the Mahometans particularly the more dissolute, who take it to intoxicate and ease pain- the chief ingredients employed in making it are *ganja* leaves (cannabis sativa), milk, ghee, poppy seeds, flowers of the thorn apple, the powder of the nux vomica, and sugar- an overdose of it has been known to bring on a total derangement of intellect.[17]

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[15]*British Parliamentary Papers*, p15.
[16]W.Ainslie, *Materia Indica*, (London 1826) vol.II p39.
[17]Ibid., p176.

Whilst these entries make clear the British awareness of the intoxicating, and even debilitating properties of certain mixtures of the hemp plant the entry under ganja reflects the ambivalence with which the hemp was regarded.

> The leaves of the hemp in India, are frequently added to tobacco and smoked to increase its intoxicating power; they are also sometimes prescribed in cases of diarrhoea; and in conjunction with turmeric onions, and warm ginglie oil, are made into an unction for painful, protruded piles.[18]

Apparently then, while intoxicating, the hemp was also represented as a potentially valuable medicine. This is a theme which subsequent British writers developed. W.B.O'Shaughnessy conducted a number of experiments with hemp derivatives in the 1830s the results of which were reproduced in the *Transactions of the Medical and Physical Society of Bengal.*[19] His observation of animal reactions to hemp preparations, for example a "middling-sized dog" whose "face assumed a look of utter helpless drunkenness",[20] gave him an awareness of the stupefying effects of the drug but the potential as a medicine in some of the other effects, "of stimulating the digestive organs, exciting the cerebral system [and] in allaying pain" was such that experiment on humans was decided upon. Rheumatism, Hydrophobia, Cholera, Tetanus and 'infantile convulsions' were all treated successfully with various hemp concoctions and O'Shaughnessy concluded that "in Hemp the profession has gained an anti-convulsive remedy of the greatest value".[21]

O'Shaughnessy's work continued to influence medical attitudes towards hemp derivatives in the decades subsequent to the publication of his article. Standard reference texts included extensive mentions of the published report:

> The first person, who seems to have well tested its properties is Dr. O'Shaughnessy. In his various experiments, he did not observe the least indication of pain, or any degree of convulsive movement. They all, he affirms, "led to one remarkable result, that while carnivorous animals and fish, dogs, cats, swine, vultures, crows, and adjutants invariably and speedily exhibited the intoxicating influence of the drug, the graminivorous, such as the horse,

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[18]W.Ainslie, *Materia Indica*, p109.

[19]W.B.O'Shaughnessy, 'On the Preparations of the Indian Hemp, or Gunjah (Cannabis Indica): their effects on the animal system in health, and their utility in the treatment of tetanus and other convulsive diseases', in *Transactions of the Medical and Physical Society of Bengal*, 1838-1840, pp421-461. This paper was available in the Fitz-Hugh Ludlow Hypertext Library at website <http://www.nepenthes.com/Ludlow/> 1996. References are to page numbers of the text when downloaded and not to the original page numbers of 1838-40.

[20]Ibid., p7.

[21]Ibid., p14.

> deer, monkey, goat, sheep, and cow, experienced but trivial effects from any dose that was administered.[22]

and often warmed to the theme of the effects of hemp: "In India it is spoken of as the increaser of pleasure, the exciter of desires, the cementer of friendship, the laughter-mover, and the causer of the reeling gait".[23]

The change in attitudes and emphasis in considering hemp derivatives is highlighted by following the occasional mentions of hemp derivatives in the *Lancet*. In 1860[24] an article was published detailing the use a doctor in Australia had made of tincture of Indian hemp in dealing with two cases of tetanus, and in 1872 it was noted in a feature that

> under care at present are two female patients, the one forty-one, the other fifty years of age, and both married, who have been for many years subject to sick headache. They have been greatly benefited by the administration of ten-minim doses of tincture of Indian hemp three times daily, between the attacks.[25]

Here it is worth considering again that postmortem report in the *Lancet* in 1880 mentioned above; *Poisoning by Indian Hemp; Autopsy.*[26] The significance of the emphasis in the article is that the focus of medical investigation is no longer the drug but the drug-user. The title and introductory biographical details emphasize that the object of the autopsy is not to be known as a man, but as a hemp-user. The piece is an exploration of the body of a known category of human, the hemp-user. Thus by about 1880 it would seem that the attitude towards hemp derivatives had changed. Rather than being a potentially useful medicine with intoxicating side-effects it had become the possible cause or was certainly a symptom of a dangerous and unpredictable character.

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[22]R.Dunglison, *New Remedies, Pharmaceutically and Therapeutically Considered*, (Philadelphia 1843), p2. Excerpts from this book were available in the Fitz-Hugh Ludlow Hypertext Library at website <http://www.nepenthes.com/Ludlow/> 1996. References are to page numbers of the text when downloaded and not to the original page numbers.

[23]James F.Johnston, *Chemistry of Common Life*, (New York 1855), p3. Excerpts from this book were available in the Fitz-Hugh Ludlow Hypertext Library at website <http://www.nepenthes.com/Ludlow/> 1996. References are to page numbers of the text when downloaded and not to the original page numbers.

[24]W.Farrage, 'Two cases of Idiopathic tetanus treated by Indian hemp, in *Lancet* 15 September 1860, p262.

[25]J.Murray, 'Middlesex Hospital Cases under the care of Dr. John Murray: Cases of Sick headache treated successfully by Indian hemp', in *The Lancet* (20 April 1872), p539.

[26]'Poisoning by Indian Hemp', p585.

The insinuation of hemp into a number of discourses partially explains the development of negative connotations of hemp use and these discourses will be looked at first. It must be borne in mind however that negative connotations attached to a narcotic does not explain how people come to be assessed as 'ganja-smokers', in other words suspicion of a substance does not necessarily result in the classification of a human type.

Hemp and the alcohol/opium debates.

Hemp narcotics were hardly known in Britain and it seems true that "there was no perceived problem of domestic cannabis use".[27] However hemp, by virtue of its intoxicating properties, was compared with alcohol and opium in official circles in India:

> In his own court Commissioner has seen more than one instance in which the criminal pleaded, in excuse or explanation of violence or murder, that the crime was committed when under the influence of bhang; and there is in his mind no doubt that the use of the drug operates much as intoxicating liquors do in England, by stimulating the passions and weakening the power of self-control.[28]

This meant that on the basis of sharing the propensity to intoxicate, the preparations of hemp were insinuated into the whole series of discourses on morality, character and social or medical intervention which had developed around alcohol use in Britain.

Various reasons have been suggested for the growing concern over popular uses of stimulants and intoxicants, including class,[29] the goals and role of the medical profession[30] or the rational culture of capitalism.[31] Whatever the origin of the fears it seems that since the gin scare of the eighteenth century in England alcoholic drinks had been linked to "not only momentary fury ... but incurable debility and lingering diseases; they not only fill our streets with madmen, and prisons with criminals, but our hospitals with cripples".[32]

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[27]V.Berridge and G.Edwards, *Opium and the People: opiate use in nineteenth century England*, (St.Martin's Press London 1981), p213.
[28]*British Parliamentary Papers*, p48.
[29]See J.Rumbarger, *Profits, Power and Prohibition: Alcohol Reform and the Industrializing of America*, (State University of New York Press 1989), pp.xiii-xiv of preface.
[30]See T.Parssinen and K.Kerner, 'Development of the Disease Model of Drug Addiction in Britain 1870-1926', in *Medical History*, Vol.24 1980, pp275-296.
[31]See G.Harding, 'Constructing addiction as a moral failing', in *Sociology of Health and Illness*, Vol.8 1986, pp75-85.
[32]Lord Lonsdale (1743) quoted in B.Inglis, *The Forbidden Game: A social history of drugs*, (Hodder and Stoughton London 1975), p69.

Increasingly from the 1850s opiates were compared to alcohol, and drugs entered the arena of social problems. This meant that hemp became associated with a number of negative characteristics. Habitual use of alcohol and opium could lead to physical impairment. Of opium it was said that

> I fully anticipate that this habit will be found not less destructive than the vice of drinking spirits. I cannot bring myself to think that the habitual use of a drug which produces such permanent effects as opium, which greatly disorders the digestive functions, leaves those who use it habitually in so miserable a state during the intervals of using it, and leads to an early worn-out appearance, can be consistent in general with enjoyment of health, and the prolongation of life.[33]

The moral character was also a focus of concern, with pronouncements such as those quoted in Harding that use of opium as a stimulant "affected all that was good and virtuous in women, it acted as an aphrodisiac and subverted all morality".[34] Over time this concern with the morality of the opium user switched from what the opium did to the user to what use of opium revealed about the user. Harding concludes in his study of the Society for the Suppression of the Opium Trade that the development of a moral-pathological model of addiction meant that "the addict could be cast, not as a victim of opium, but as an irresponsible individual willfully adopting a course of self-destruction- fully aware of the probable consequences but unable to resist the drug induced craving. In other words, a 'willing victim'",[35] and Peters concludes that as regards both alcohol and opium, "excessive dependence on either was popularly considered evidence of weak character".[36]

In other words intoxicants and stimulants like alcohol and opium, to which hemp was explicitly compared in British India were seen as a guaranteed route to physical, mental and moral impairment. The development of the moral-pathological model created a cultural environment where the user of such intoxicants was portrayed as happily abandoning him/herself to such damage in pursuit of the short-term pleasures. In other words the use of intoxicants was a sign by which the weak and the willful might be known, it became a signifier of moral character.

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[33]Excerpt from R.Christison, 'A Treatise on Poisons' (Edinburgh 1845) quoted in D.Peters, 'The British Medical Response to Opiate addiction in the nineteenth century', in *Journal of the History of Medicine and Allied Sciences*, Vol.XXXVI 1981, p468.

[34]Excerpt from Dr. Thomson in 'Medical Times', no.1 1840, quoted in Harding, 'Constructing addiction as a moral failing', p78.

[35]Ibid., p82.

[36]D.Peters, 'The British Medical Response to Opiate addiction in the nineteenth century', p468.

Nikolas Rose suggests that the pauper vagrant was anathema to modern government throughout the nineteenth century:

> Pauperism was a rejection of regular employment which meant also an existence outside the benign self-regulating mechanisms of the economy ... a refusal of all those relations which were so essential to a healthy, wealthy and well-ordered polity.[37]

This was certainly the case in India where "British rulers did not consider mobilization as their business, nor did they think that India as a whole was capable of it anyway ... it was enough within India to keep order".[38]

Numerous examples are available in official correspondence which show the concern of the colonial authorities with wandering people. These will be looked at in more detail later but an example will suffice here. Despite evidence of the truth of their claim to be horse traders[39] a group of Indians and Beluchis was deported in 1880 for the simple reason that they were "foreign vagrants".[40] This follows on from a case in 1878 in which the Home Department had to deal with what it called the problem of "sturdy beggars" and "professional beggars, if not thieves"[41] which wandered Sind, which the Government ultimately dealt with by ordering the wandering groups out of India with the penalty for refusing to do so being apprehension and confinement.

The response of the authorities to individual wanderers seems much the same as that contemplated for the groups caught at loose in Sind. The available case notes of lunatic asylums show that incarceration was often the fate of the vagrant.

> Nurput Singh. Dementia. 25. Beggar. 22 May 1863.
>
> Sent in from Hurdui, was found wandering about the district. Appears quiet- is unable to comprehend ordinary questions- general incoherence of language- unsteady look about the eyes.
>
> 4 June. Much improved.

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[37]N.Rose, *The psychological complex: psychology, politics and society in England, 1869-1939*, (Routledge London 1985), p45.
[38]D.Lelyveld, 'Colonial Knowledge and the Fate of Hindustani', in *Society for Comparative Study of History and Society*, 1993, p681.
[39]The letter from the Deputy Commissioner to Sind admits that they had plenty of ponies with them and carried permits for their weapons.
[40]Dep.Comm.Sind to Governor Bombay, 16 Jan 1879, GOI (Public) Procs Feb 1880, 72B.
[41]Home Department comments on GOI (Public) Procs April 1878, 103-107A.

> Nov. This man has been suffering long from Diarrhoea. It exhausted him + on Nov. 13th he died.[42]

An unreadiness to cooperate and a mobile lifestyle are all that are recorded on this case history and yet the individual is incarcerated in an asylum in which he quickly becomes ill and dies. The British policy of incarcerating vagrant Indians in lunatic asylums is dealt with more fully later in this project but it is clear that the individual wanderer concerned the authorities as much as did larger wandering groups. Further case notes suggest that gradually hemp use was being associated with the lifestyle of the vagrant at the asylum.

> Banda Ally Khan. Mania. Moosal. Beggar. 35. 2 Aug/61.
>
> 1861 Oct. This man was sent in by City Magistrate. He had been found in the streets and could give no satisfactory account of himself. On admission he appeared to be labouring under the effects of some intoxicating drug. His conduct did not appear anyways unusual excepting that he devoted a very long time to prayer. After keeping him under surveillance for two months, I considered that no necessity remained for a larger period of confinement and he was released 8th October 1861.[43]

From such connections on the case note comes the sweeping generalization in the asylum report, Dr. Wylie at Ahmedabad asserting that "an addiction to the drug [is] seemingly a tolerably common proclivity in vagabond life".[44] These associations gradually entered the discussions of colonial government so that the opinions of asylum doctors were given credence by non-medical officers:

> Beggars also gave a large number of admissions, for the reason, no doubt stated by Dr. Corbyn (Bareilly) that, 'in addition to general indulgence in bhang and churrus, they are much more exposed than any other class to the heat of the sun and the changes of the season'.[45]

By the time the replies of non-medical officers were gathered in response to the enquiry of 1871 non-medical officers like the superintendent of the Nagar Division in Mysore were happy to state that "its excessive use is confined generally to dissolute mahommedans, faquirs and idle vagrants".[46]

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[42]Case Book II, patient no.28, admitted 22 May 1863.
[43]Case Book IA, patient no.126, admitted 2 August 1861.
[44]*Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1873-74*, p31.
[45]*General Report no.6 on the Lunatic Asylums, Vaccination and Dispensaries in the Bengal Presidency 1873*, p66.
[46]*British Parliamentary Papers*, p12.

Other elements.

British attitudes towards hemp may have been affected by other discursive elements. An orientalizing thrust, where the differences of Asians and Europeans were essentialized in supposedly scientific writings, is evident in some work on hemp. The entry on hemp in the eighth edition of the *Encyclopaedia Britannica* states that "Dr. O'Shaughnessy relates some most remarkable effects of the churrus, particularly its power in producing a state of true catalepsy. The same effects do not appear to take place upon Europeans",[47] and elsewhere it was decided that "upon Europeans generally, at least in Europe, its effects have been found to be considerably less in degree than upon orientals".[48] Thus the intoxicating nature of hemp upon the Indian in these scientific texts may have been exaggerated or generalized to emphasize the difference between the Indian and the European temperaments.[49]

There is also evidence that the opinions of certain Indians had influenced British attitudes to hemp use.[50] For example, an Indian Deputy Collector was taken off of his regular duties to compile a report on hemp in 1877 and in this he provides translations of Indian words for hemp derivatives, "*harshiní*, 'the delight-giver'; *mádini*, 'the intoxicator'; *chapalá*, 'the causer of unsteadiness".[51] He points out that

> the words *gánjá* and *gánjákina* as applied to hemp are the most recent. In the older dictionaries they are explained to mean a tavern, a drinking bowl, an abode of the low; and their application to the narcotic must be accepted as suggestive of the vile propensities of those who indulge in it.[52]

Elsewhere, British officers qualify an opinion on hemp use by implying consultation with local Indians, so that the Civil Surgeon of Sitapur declares: "I am aware a belief exists with many natives to the effect that long-continued and excessive use of the

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[47]*Encyclopædia Britannica or dictionary of arts, sciences, and general literature*, (eighth edition, Little, Brown, and co., Boston, MDCCLVI). Excerpts from this book were available in the Fitz-Hugh Ludlow Hypertext Library at website <http://www.nepenthes.com/Ludlow/> 1996. References are to page numbers of the text when downloaded and not to the original page numbers.

[48]James F.Johnston, *Chemistry of Common Life*, (New York 1855), p3. Excerpts from this book were available in the Fitz-Hugh Ludlow Hypertext Library at website <http://www.nepenthes.com/Ludlow/> 1996. References are to page numbers of the text when downloaded and not to the original page numbers.

[49]*British Parliamentary Papers*, pp96-154.

[50]The importance of 'native informants' in forming British opinions has received fresh emphasis recently. See C.Bayly, *Empire and Information: intelligence gathering and social communication in India, 1780-1870*, (Cambridge University Press 1996), pp369-370.

[51]*British Parliamentary Papers*, p97.

[52]Ibid.

drug has a tendency to produce insanity".[53] The Commissioner of Lucknow forwards a report on an individual in which he observes that "the people of his village are of opinion that excessive use of the drug was the cause of Bhowani's insanity".[54] Whilst the content of these statements and the process of selecting them and recording them in colonial documents are obviously problematic the statements are certainly suggestive of the influence of certain Indian discourses on the effects of hemp preparations on British perceptions of the drugs.

The propensity in this period to blame sudden violence and uncontrollable anger on hemp narcotics may be linked to other discursive elements still, to those concerned with colonial legitimacy which after the Uprising of 1857 would have acted to de-politicize violence and to discover reasons for disruptive behaviour which did not implicate the colonial order. Whatever the specifics though, it can be said that it is certainly possible to trace a discursive context in which hemp use and hemp users gradually came to take on negative associations in the imagination of the British in India. However, tracing the growing distrust of hemp derivatives is not the same as tracing the emergence of a human type, the hemp user, in colonial discourse. It is necessary to explain the process by which the figure of the ganja-smoker emerged from a general suspicion of preparations of cannabis.

Colonial Discourse and the Medical Site.

Consider David Arnold's conclusion in his piece dealing with the prisons of the British colonial system in India:

> I would argue that medical research and administration in Indian prisons had an exceptional role not only in medical research but also in creating a colonial discourse about Indian society and the Indian body.[55]

He is arguing that the prison was a site, one of the few such sites, where the British had unlimited access to the Indian body and so the information gathered there was thought to apply to all of India and all Indians rather than just to those who ended up within the prison walls. It is argued that the asylum was another such site, as the British medical officer came into daily contact with the Indian body, and crucially in

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[53] *British Parliamentary Papers*, p52.
[54] Ibid., p47.
[55] D.Arnold, 'The Colonial prison: power, knowledge and penology in nineteenth-century India', in D.Arnold and D.Hardiman (eds.), *Subaltern Studies VIII*, (Oxford University Press 1994), p179.

the asylum, with Indian behaviour. What he observed was recorded and universalized as with similar knowledge generated at the prisons.

Arnold quite rightly identifies the relationship between knowledge generated in the institutions and broader colonial discursive construction but he does not detail the process by which this relationship develops. By tracing the figure of the 'ganja-smoker' or hemp user back to the asylum though it is possible to see how this happens.

Arjun Appadurai identifies two stages by which colonial knowledge is generated and develops into broader discourses on the colonized society: categorization and enumeration.[56] He explains that the anthropological work of eighteenth and early nineteenth century colonizers emphasized the importance of caste as the key for the British to mapping Indian society, but it was only when the census provided a means of counting people within the categories of the caste system that that knowledge system became the predominant mode of conceiving of Indian society. The census was so important as

> numbers were a critical part of the discourse of the colonial state, because the metropolitan interlocutors of the colonial state had come to depend on numerical data, however dubious their accuracy and relevance, for major social or resource-related policy initiatives.[57]

For an issue to become a concern of government it needed to be packaged in a set of statistics as "numerical glosses constituted a kind of meta-language for colonial bureaucratic discourse within which more exotic understandings could be packaged".[58]

When tracing the 'ganja-smoker' through colonial discourse then, it is possible to link Arnold's point about the prison as a site with Appadurai's hypothesis about the processes of categorization and enumeration in the generation of colonial knowledge. Quite simply, the asylum acted as the prison did in Arnold's account, that is as the site where the British had unlimited access to the Indian body and behaviour and the information produced at that site acted to develop the 'ganja-smoker' as a category. Significantly though, it was also the asylum which generated the statistics, 'however

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[56]A.Appadurai, 'Number in the Colonial Imagination', in C.A.Breckenridge and Peter van der Veer (eds.), *Orientalism and the Postcolonial Predicament: Perspectives on South Asia* (University of Pennsylvania Press 1993), p335.
[57]Ibid., p319.
[58]Ibid., p326.

dubious their accuracy or relevance', which translated that category into the statistical meta-language of the colonial state.

The Asylum and Categorization.

Various accounts have shown how the lunatic asylum in Europe was an important element in modern government,[59] and as already stated Nikolas Rose finds in the psycho-sciences key techniques for the observing and mapping of the 'problematic sectors' of the European population.

The asylum in British India was no exception as the British medical officers with jurisdiction took full advantage of the opportunity presented to them of a captive population of Indians to observe and explore their bodies and behaviour. The most striking example of this was the post-mortem examination. The process of exploring the body after death was considered an important tool by Western medicine for accumulating knowledge but in India "dissection and the study of anatomy had not been part of Hindu (or Muslim) medical practice in recent centuries",[60] and indeed there existed "a deep loathing of dissection"[61] in Indian culture. The asylum was a place where many of the inmates were admitted from a lifestyle of vagrancy and who subsequently died without anyone to take responsibility for the body. It was therefore an opportunity to get access to the otherwise hidden body of the Indian.

Consider for example the tone of J.B.Scriven the superintendent of the Lahore asylum in 1874.

> One of the advantages accruing from the appointment of an intelligent Assistant Surgeon to the post of Deputy Superintendent will be the opportunity of making some pathological investigations into the causes of insanity by means of post-mortem examinations. I have always regretted the absence of means for doing this. This defect will now be remedied, as Government has sanctioned the building of a post-mortem room, which I hope will be completed in 1875.[62]

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[59]See for example, M.Foucault, *Madness and Civilization: a history of insanity in the age of reason* (Routledge London 1989); A.Scull, 'Humanitarianism or Control? Some observations on the historiography of Anglo-American psychiatry', in S.Cohen and A.Scull, *Social Control and the State* (Basil Blackwell Oxford 1985), p134; E.Showalter, *The Female Malady: women, madness and English culture 1830-1980*, (Virago London 1987).

[60]D.Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, (Oxford University Press 1993), p5.

[61]Ibid., p6.

[62]*Annual Report on the Lunatic Asylums in the Punjab for the Year 1874*, p22.

It seems that when all the conditions came together, an able assistant and the support of the government, the superintendent wastes no time. In the report of 1876 is the statement that:

> A post-mortem examination is now made of every patient that dies in the Asylum, unless the friends object. Thirty-four such examinations have been made during the past year. An annual report is not the place to record pathological appearances, nor have the investigations yet been numerous enough for a special report; but there is no doubt that as the records accumulate during the next few years, they will become exceedingly valuable, and throw light upon a branch of medical science heretofore too little studied.[63]

Unless there exists an interested party to stop the doctors the Indian inmate is routinely dissected on death and the body explored in the name of medical knowledge. The design of the Lahore asylum itself reflects the determination of the superintendent to have a place for access to the body of Indians but also an awareness that such a place must be set apart from the routine functioning of the asylum such was the loathing of dissection among Indians (see Figure II).[64] This situation is only possible in India in an institution like the asylum where colonial medicine could have the unlimited access to the body of the colonized subject denied it by indigenous culture. It was in observing and recording the body and behaviour of those deemed to be hemp users that the category of the 'ganja-user' was built up.

Hemp as Madness.

While the asylum was a fine place for observing the Indian it still does not explain why the medical officers there thought they were observing a class of 'ganja-smokers' or hemp users. Two of the reasons why the superintendents thought so many of the people that they saw in the asylum were there because of excessive use of hemp were that the medical officers were told this by the policemen that had picked them up and perhaps more importantly that the doctors were happy to believe this police information.

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[63] *Asylums in the Punjab for the Year 1876*, p3.
[64] *Asylums in the Punjab for the Year 1875*, pp20-21.

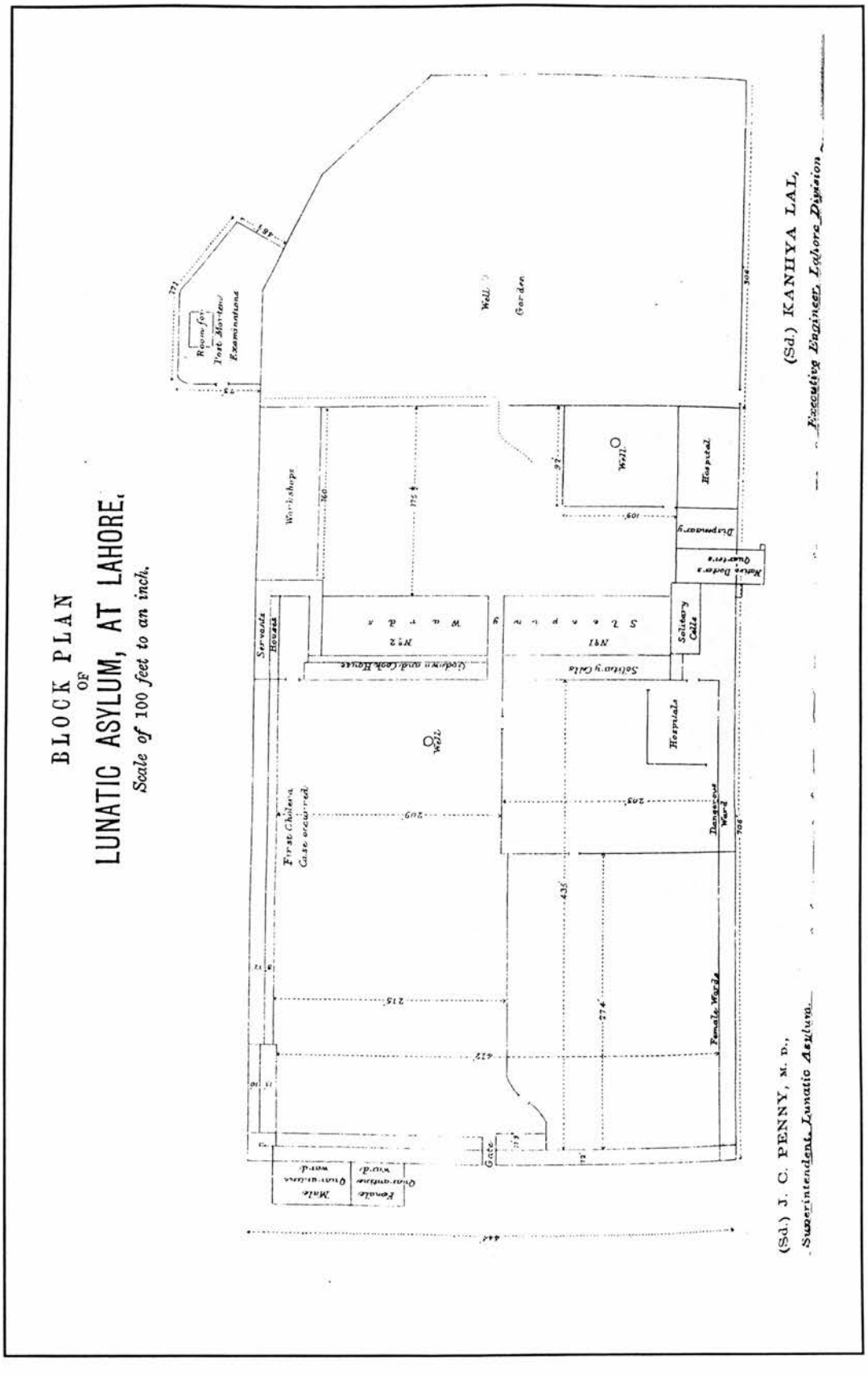

Figure II. The Lahore Asylum 1875.

Consider the opinion of the Dr. Simpson in the asylums report for Bengal in 1874:

> Among the pauper class information as to the cause, unless the case be that of a known ganja-smoker, is often not procurable; and as the formal statement of the cases includes a direct question, an imaginary cause is entered.[65]

He goes on to point out that "judging from the style of the answers furnished by the police in the descriptive rolls, it would appear that if the man be a ganjah-smoker the drug is invariably put down by them as the cause of insanity".[66] What he is describing is a process in which the police, who needed to come up with a cause of insanity to have the forms filled in correctly, often could find no evidence of what had disrupted the behaviour of the individual that they wished to incarcerate. This meant that they would have to make one up, and in such a situation ganjah-smoking was a convenient and accepted way of filling the form up and one that was likely to be believed. This is the second part of the explanation, such an entry on the form was likely to be given credence by the medical officer at the asylum. In explaining this there is no doubt that many held with the idea that ganja was comparable to alcohol and opium etc. and was therefore an irredeemable evil likely to lead to mental problems. There was also a more specific reason why this credence was given.

Throughout the nineteenth century medicine in Europe was struggling to assert its authority over the psyche, in other words doctors needed to prove that the brain and its workings was properly their concern and not the concern of other professional groups like the clergy who were also involved with the care of the individual. Sally Swartz identifies a similar process in asylums in the Cape Colony where

> ascribing aetiologies was important because it gave a sense, often illusory, of having the means to predict, prevent and control the spread of mental disorder.[67]

Blaming hemp was a simple and plausible way of ascribing the aetiology of mental disease in India which thereby reinforced the medical officer's claim that they knew what they were talking about.

The medical officers were thus convinced that they were observing hemp users. What they observed was somebody who had only come to their attention in the first place at

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[65] *Annual Report on the Insane Asylums in Bengal for the Year 1874*, p16.
[66] Ibid.
[67] S.Swartz, 'Colonizing the insane: causes of insanity in the Cape, 1891-1920', in *History of the Human Sciences*, vol.8 no.4 November 1995, p40.

the asylum as their behaviour was so visibly disordered or disruptive that the police had felt it necessary to intervene. So, convinced that they were observing hemp users the medical officers came to associate such people with aberrant behaviour. Consider the following case notes from the Lucknow asylum for the period 1859-1872.

> Bhugwan Dass. Mania acute. 26. Hindoo. labour. 23 Feby/69.
> Certified by Magistrate violent
>
> 28 Feb 1869. Probably from bhung. He is very troublesome + destructive. Sent in by City Magistrate of Lucknow.
>
> 3rd May. Made over to his friends by order of the committee.[68]

As this is the entire case note it seems that all the information available for Bhugwan Dass is that he was destructive and this was thought to have been the result of the man's use of a preparation of hemp. The implication of the qualification 'probably' suggests that the medical officer has no direct evidence that hemp was the cause of the man's behaviour yet he is happy to record the conjecture and thus the case note becomes the site where the authority of Western science is lent to the idea that hemp users are liable to sudden violence. The case note is after all a scientific document, prepared by a specialist in the science of the body. Associations formed on it carry their own peculiar power as they represent, in Western eyes, expert opinion.

Consider then the following examples:

> Khoola Buksh- M. Mania. 15. Mussulman. Beggar. 12 Sept/62.
>
> 1862 Sept. This little scamp was sent in by City Magistrate. On admission he was evidently under the influence of some intoxicating drug. He was almost speechless and idiotic- could scarcely feed and was insensible and apathetic to all which passed around him. I have subsequently ascertained that he was greatly addicted to Gunja- by care and attention his general health improved and appetite returned and his expression became mild and natural. He is now well.[69]

The narcotics user here is recorded as being helpless and insensible, unable even to feed himself, let alone communicate with those around him. The behaviour of the hemp user was also often self-destructive.

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[68]Case Book IV, patient no.38, admitted 23 February 1869.
[69]Case Book IA, patient no.227, admitted 12 September 1862.

Allya Khan. M. Mania. 30. Mussulman. Coolie. 17th Jany/63.

1863. Sent in by City Magistrate found wandering about Bazar in City is an inhabitant of Lucknow ... apparently had been smoking and using some drugs to excess was violent on admission.

Discharged much improved. Made over to his friends.

June 10th. Readmitted having thrown himself down a well. Is worse than ever.[70]

From such individual instances of Indian bodies interacting (or so we are led to believe) with the hemp narcotic are built grand generalizations.

> Each and all of these forms of Indian hemp act on the nervous system, exercising a peculiar influence over the brain and spinal chord, and their nerves. They also paralyze the sympathetic nervous system, as shown in the arrest of the secretion of the salivary glands ... There is a state of brain produced by over-indulgence in bhang or charas, which corresponds to delirium tremens; sudden suspension of its use causing a state of most violent excitement. The patient talks incessantly; pelts those about him with bricks or stones; bites and tears his clothes; and it would be dangerous to approach him... He may die from exhaustion of the brain, or stoppage of the heart's action from paralysis of the sympathetic, or he may gradually recover.[71]

This report is included in the replies of the Bengal Government to the enquiry of 1871 and is an extract from Dr. Penny's report on the Patna asylum. Despite the fact that the sample from which he has formed his opinions are simply those he has watched in the asylum, he generalizes or universalizes his conclusions and talks of 'the brain' or 'the nervous system' rather than specific brains or individual nervous systems. Having universalized his subject he moves on to the effects of hemp and then on to the behaviour of the hemp user, who is violent and dangerous, and indeed liable to sudden death.

This is the crucial step between observing individuals at the asylum and producing the figure of the 'ganja-smoker' in colonial discourse. The specific becomes the universal, in other words the disordered individual whose odd behaviour has been linked at the asylum with hemp use becomes representative of all hemp users as he is the only point of access that the British, and especially those with the medical training to claim scientific authority for their opinions, have to Indian people thought to use hemp. The ordinary Indian who while going about his business enjoys a smoke or a drink of some hemp preparation will never come to the attention of the British and be examined or recorded by them. Rather it is the disordered individual available to the

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[70]Case Book II, patient no.4, admitted 17 January 1863.
[71]*British Parliamentary Papers*, pp14-15.

medical gaze in the institutional setting of the asylum and produced on the case note as a hemp user that represents the sole access that the British have to Indians thought to use hemp. Thus their violence, weakness or disruption comes to be typical of people who use hemp.

Identifying the 'Hemp user'.

If the asylum was the site where the link between the 'hemp user', madness and violence was established through the medical officers' access to the Indian body, it was the access at this site which also afforded the means of identifying the danger. In other words, the category of the hemp user was established not just through identifying the characteristic behaviour that might be expected of such a human type but also through the identification of the physical characteristics of that type.

The search for physical manifestations of mental type is familiar from various accounts of nineteenth century medical research. Jan Goldstein in his study of French psychiatry conjures up the image of the "'sharp-eyed' psychiatrist, whose classification of diseases by their visible signs is his stock in trade and his claim to power",[72] and goes on to mention the boon photography gave in the compilation of "a giant and often grotesque archive of the iconography of nervous illness, extending ... to bodily postures as well as to facial expressions".[73]

The best known example of attempts to establish a system of irrefutable physical signifiers of moral and mental capacities and processes is the project of phrenology.[74] The phrenologist believed that the careful classification of head size, volume and shape would lead to an understanding of brain size and therefore to an understanding of the nature of any individual studied. Rather than rely on the impressions one had of an individual, the scientific analysis of his head would give the observer the measure of the man/woman. As De Giustino points out in his study of British phrenology there thus grew up a generation of "men who believed in the shape of the head as an index to character",[75] where leading exponents of the 'science' "boasted of phrenology as

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[72]J.Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century*, (Cambridge University Press 1987), p378.
[73]Ibid., p380.
[74]For a discussion of the significance of phrenology in colonial discourses on race see C.Bates, 'Race, caste and tribe in central India', in P.Robb (ed.), *The Concept of Race in South Asia*, (Oxford University Press 1995), pp219-259.
[75]David de Giustino, *Conquest of Mind: Phrenology and Victorian Social Thought*, (Croom Helm London 1975), p136.

the useful and long-awaited instrument for separating good men from bad".[76] Measurements of the head though were just one example of the many ways tangible physical indicators of mental condition were sought. Smell was even suggested as a means of identifying mental states:

> Mania especially is characterized by a peculiar odour. It is not the *hircum olet* of Horace, but is a smell quite unique: and when once recognized, it can never be mistaken for any other. It has been compared to the scent of henbane in a state of fermentation; but I know nothing of which it resembles ... The knowledge of this physiological fact may be found very useful as a test of mental derangement, when there is difficulty in deciding.[77]

The desire in India to observe physical signifiers believed to be important in divining mental state or capacity is shown in the case notes by the occasional note of a phrenological nature. Although never systematic, different doctors at different times did record information on cranial measurements. In 1860 the doctor in charge in Lucknow records that Chumula, "a stout boy ... has a low forehead and narrow head",[78] while in 1868 the note "circum. of head 20 inches" follows the information that Kudhlay was "V.violent + dirty. To be kept under strict observation. Destroyed two blankets".[79]

Various accounts show that doctors used the asylum in colonial India as a site to observe the body of the hemp user, and to build up a picture in their own minds of the physical features by which a user could be recognized. Dr. Penny was mentioned earlier on as he described the physical characteristics of hemp users, "Old Bhang drinkers, charas and ganja-smokers and majum-eaters are, as a rule, emaciated. They lose vital energy, become impotent, forgetful, weak-minded and melancholy ... again charas-smokers are often asthmatic."[80] The information contained in the Patna superintendent's report for 1868 is even more direct. Consider the page reproduced from the report (Figure III see over).[81]

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[76]David de Giustino, *Conquest of Mind*, p139.
[77]excerpt from George Man Burrows, 'Commentaries on Insanity', in V.Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century*, (Routledge+Kegan Paul London 1975), pp78-9.
[78]Case Book IA, patient no.15, admitted 13 May 1860.
[79]Case Book IV, patient no.20, admitted 17 November 1868.
[80]*British Parliamentary Papers*, p15.
[81]*Asylums in Bengal for the Year 1868*, p37.

X. Seeing that so many of the cases admitted into our asylums result from over indulgence in gunjah or bhang, and are not really cases of insanity, I find some difficulty in classing them, and accordingly venture to suggest that all such cases be included under the head of *Cannabism*; they are easy of recognition, and the following characteristics will assist in determining them. In a recent case the conjunctivæ are congested, the pupils generally contracted, and the countennnce wears a peculiar *leery* look, which, when once seen, is unmistakable. The pulse may or may not be accelerated, and there is a marked unsteadiness in the gait; great volubility or continued indulgence in laughter or song. If the muscular system is greatly excited, there is a tendency even to rush wildly onwards in a straight line—unmindful of intervening obstacles, and consequently severe bruises, especially about the shins, are often met with. These are indications to be met with in a novice, and I cannot find that there are any unpleasant after-consequences in coming out of the debauch, which, on the whole, seems to be a happy and merry state of intoxication. One woman, describing her sensations, said that she felt as if her spirit wished to pass upwards through the skull, and that her body longed to mount upwards as well.

Bhang drinking, as opposed to gunjah smoking, seems to induce pleasant reveries, like those produced by morphia when the tendency to sleep is resisted. It is enormously indulged in, far more so than gunjah, but easily overlooked owing to the absence of excitement. In the confirmed gunjah smoker, there is greater stupidity and less excitement, a kind of mandlin intoxication with conjunctivæ markedly red. Two tests at once betray the habitué; by frequently rubbing up the gunjah and tobacco in the left palm with the right thumb a corn is produced on the outside of the last phalanx, as shown on the margin, and if you place before him a chelum said to be charged with gunjah, he will inhale the smoke with one long prolonged whiff, which would at once bring on coughing in the non-initiated. A confirmed gunjah smoker has frequently dark, purple lips, but the corn and inhalation will always reveal him.

Figure III. The Ganja-corn.

Surgeon Hutchinson has gone as far as to graphically represent the finger of a "confirmed gunjah-smoker" in order to offer an easy means of identifying such a figure. The language he uses confirms his project in producing the drawing, he is hoping to pass on physical information which will certainly, "betray the habitué", and ultimately, "reveal him". Such language suggests that he believes hemp-users to be surreptitious and that there is a need to establish foolproof ways of uncovering them. He sees the corn as a form of stigmata, an irrefutable sign which when read informs

the observer that the man is a hemp-user and is therefore under suspicion of being mad, violent, self-destructive etc. He supplies additional helpful information, noting such things as, "a peculiar leery look which, when once seen is unmistakable", and pointing out that, "a confirmed gunjah smoker has frequently dark, purple lips", but whatever the difficulties of these indicators he assures the reader that, "the corn and inhalation will always reveal him". He is plainly trying to record ways in which the hemp-user might be recognized physically and in the process creates an image to be attached to a human type or category. The asylum then was the site where the hemp user of the colonial imagination was quite literally 'given flesh'.

To summarize then, the information that marked out the 'ganja-user' as a particular category of Indian society, that is the data on the distinct behavioural and physical characteristics peculiar to that type, was produced at the site of the lunatic asylum. It made no difference to the colonial authorities that the sample of humans from which they drew their knowledge was a specific and unrepresentative group, that is people who had ended up in the asylum because of deviant or disruptive behaviour. Rather, the colonial authorities privileged the information produced at the asylum as it was one of the few places its scientific experts had access to the Indian's body and behaviour. In this way the disordered individual, accused of using hemp preparations for the sake of administrative convenience or professional pride and dragged into the asylum for making a fuss or getting in the way, came to be representative of a human category in Indian society.

The Asylum and Enumeration.

Yet the process of categorization, the observation of characteristics and the assignment of type is only one part of the process that Appadurai says is crucial to the production of official knowledge.[82] His study is of caste groups and the census, and it is his contention that the census was the site of the enumeration of caste groups, a process which established such groups as the British mode of conceptualizing Indian society and a central focus of their policies. This final part of this article looks at the asylum as the site of the statistical creation of hemp users and the way that these statistics 'however dubious their accuracy and relevance' allowed the hemp user to enter the discourse of colonial government.

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[82]A.Appadurai, 'Number in the Colonial Imagination', pp314-339.

In amongst the variety of data collected at the asylum and compiled in the asylum statistics was information on 'cause of insanity of those admitted'. In Bengal, where the statistics collected were most complex, there were 21 possible causes mooted in the various asylums in 1870, 22 in 1875. They were divided into physical causes and moral causes. Amongst the physical were such factors as 'epilepsy' or 'miscarriage' and among the moral 'grief' or 'family quarrel'. Gunjah customarily occupied the first slot in the known physical causes and always predominated in every asylum in India throughout the 1860s and 1870s.

The passing of comment on the preponderance of hemp narcotics in the statistical table on causes became a routine part of the statement of superintendents. For example, the superintendent of Dullunda comments in 1867 that

> among the causes of admissions, there appear nothing of novelty or special interest. The fact which each succeeding year brings prominently forward, of the prevalence of ganja smoking as a fertile source of insanity is as prominent as ever in the records of 1867.[83]

In 1871 Surgeon Cutcliffe points out in his report on the asylum at Dacca that "Table no.4 shows the causes to which the insanity of the patients has been attributed. 33 percent of all the cases are attributed to gunja smoking and 7.18 to spirit drinking".[84] In 1875 the officer in charge of the asylum in Cuttack pointed out that "Ganja is reputed as the cause of the majority of the admissions and nearly half of the admissions during the past ten years into this asylum are attributed to its abuse".[85]

Almost as routine is the casting of doubt about the reliability of these figures. In 1871 the superintendent voiced his concern that "causation is, as usual, very unsatisfactorily noted among the admissions. Antecedent information is commonly difficult to procure. Intemperance is an assigned cause in 9 cases, but with one or two exceptions I doubt whether it can be regarded as in any sense a true cause in this number".[86]

Surgeon Wise admitted in 1872 that

> an attempt has been made this year to distinguish between those cases of insanity clearly due to ganjah-smoking and those in which the use of ganjah has only been occasional, and therefore insufficient to excite insanity. The attempt has not been successful. For want of any other

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[83] *Asylums in Bengal for the Year 1867*, p10.
[84] *Asylums in Bengal for the Year 1870*, p35.
[85] *Asylums in Bengal for the Year 1875*, p24.
[86] *Asylums in Bengal for the Year 1871*, p75.

> reason, it has been necessary to enter under the heading of ganja several who were merely reported to have indulged in its use.[87]

Dr. Simpson was aware of the problems of the statistics but was still happy to base an opinion on them: "Judging from the style of the answers furnished by the police in the descriptive rolls, it would appear that if the man be a ganjah-smoker the drug is invariably put down by them as the cause of insanity. However this may be, the figures in Table no.7 impress one with the conviction that ganjah, bhang and alcohol have more to do with the peopling of our asylums than all other cases put together".[88]

The concern with the accuracy of the statistics was not just restricted to medical officers in Bengal. The medical officer at the Delhi asylum points out that, "I know the difficulties of obtaining information when perhaps the constable who seizes [or] the Thannadar or Deputy Inspector who receives the charge, is himself wanting intelligence".[89] As late as 1880 Dr. Rice at Jubbulpore is still concerned to establish that

> the determination of causes of insanity is of considerably greater difficulty than the classification of the variety. Only too often it is impossible to procure any previous history of the patient. Native relatives (even if any exist and are willing to do so) are not skillful in depicting those traits of character previous to his seizure which might tend to show what led to his becoming insane: but too often the man has no known relatives, and 'shots' are made by the neighbours as to the cause of his madness.[90]

It is crucial to note though that despite the constant concern over the relevance and accuracy of the statistics they were still registered by the non-medical officers reading the reports and policy was generated on the basis of those numbers. In the report for 1873 for example Surgeon-Major Cayley makes it clear that "I fear that not much reliance can be placed on the alleged causes of insanity ... it is difficult to ascertain if ganja was the actual cause in so many cases".[91] However the Judicial Department resolution at the end of that same report considered that "there is little calling for remark on the present report on the types of insanity or its causes. Of the exciting causes of insanity, ganjah-smoking is still shown in the returns for the whole of the Lower Provinces as one of the most frequent; and it is observable that in many cases of re-admission the patients are said to have been confirmed smokers of the drug". On

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[87] *Asylums in Bengal for the Year 1872*, p65.
[88] *Asylums in Bengal for the Year 1874*, p16.
[89] *Asylums in the Punjab for the Year 1871-72*, p2
[90] *Report on the Lunatic Asylums in the Central Provinces for the Year 1880*, p7.
[91] *Asylums in Bengal for the Year 1873*, p63.

the basis of this observation of the statistics "the Lieutenant-Governor is giving special attention to the best means for further augmenting the check (which has been imposed of late years apparently with some success) on the consumption of this most deleterious drug".[92]

Indeed the importance of the statistics generated in the asylums in securing the entry of the hemp user into the discourse of colonial government is underlined by the significance attached to those statistics in the enquiry of 1871. The statistics produced in the medical institutions are reproduced in replies of non-medical officers to the enquiry. The reply from the office of the Chief Commissioner to the Central Provinces includes the information that

> Dr. Beatson, Civil Surgeon Nagpur and superintendent of the asylum reports that out of 317 lunatics received into the asylum since 1864, there were 61 in whom insanity had been occasioned by an immoderate indulgence in ganja. Of these 61, 10 have died, 28 have been discharged cured and 23 remain uncured. He therefore concludes that excess in ganja smoking does produce an insanity which is transient if the habit is relinquished but otherwise permanent.[93]

Similarly, the reply from Mysore quotes the figures of the asylum superintendent Dr. Ranking which show "that out of a total of 250 admissions in the lunatic asylum in Bangalore during the past five years the use of ganja is assigned as the cause of insanity in 82 cases, but 64 persons of the number so affected subsequently recovered their reason, and were discharged".[94] The whole report of Dr. Penny at the Delhi asylum is reproduced in the reply of the Punjab and a statistical table tracing the percentages of the total treated for hemp-related mental disorders in the years 1867-1871 is recorded. This shows an increasing percentage of those treated to be attributable to hemp. He also takes the trouble to reproduce "a reference to the Annual Report of the Lunatic Asylums in Bengal for 1871- Dullunda, Dacca, Patna, Moydapore", and finds that "cannabis constitutes 31 per cent of the whole; 78 of the known causes of insanity".[95]

Indeed the Resolution by the Government of India on the enquiry which was finally decided upon in December of 1873 itself reproduced the asylum statistics. All of the above examples are mentioned in the resolution, including a reproduction of the table of Dr. Penny and direct quotes: "Of 317 lunatics received into the Nagpur Asylum

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[92] *Asylums in Bengal for the Year 1873*, p3.
[93] *British Parliamentary Papers*, p9.
[94] Ibid., p12.
[95] Ibid., p15.

since 1864, there were 61 in whom insanity had been occasioned by an immoderate use of ganja ... From this result it is inferred that excess in ganja-smoking does produce an insanity which is transient".[96] The conclusion of the resolution states simply:

> There can, however, be no doubt that its habitual use does tend to produce insanity ... of the cases of insanity produced by the excessive use of drugs or spirits, by far the largest number must be attributed to the abuse of hemp.[97]

Quite simply the statistics produced at the asylum on the number of admissions thought to be hemp users were inaccurate and open to question. However they represented a crucial stage in the production of colonial knowledge as the statistics were a translation of a figure in the colonial imagination into the idiom of modern government, as numerical representations of ideas and phenomena had become the meta-language of bureaucratic discourse.

CONCLUSION.

It would be absurd to claim that people in India did not use hemp narcotics for a variety of reasons and it is entirely possible that its use at certain times disagreed with certain individuals to the extent that they became muddled or even murderous. The claim here has been that the image of that figure that came to predominate in colonial discourse was no simple reflection of some reality external to colonial discourse but instead was largely the product of colonial systems of gathering and disseminating information.

In the replies to the enquiry of 1871 there is plenty of evidence that the figure of the 'ganja-smoker' as dangerous or destructive was by no means fully established in the colonial imagination. Many held the view

> and apparently not without great show of reason, that persons whose employment subjects them to great exertions and fatigues, such as palki-bearers &c., are solely enabled to perform the wonderful feats that they not unfrequently do, by being supported and rendered insensible to fatigue by ganja; and the use of ganja leaves in them no after effect of an injurious kind.[98]

While these people held opinions of the hemp user which were opposed to those which regarded him as violent or lunatic there were those who seemed oblivious to the

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[96]*British Parliamentary Papers*, p88.
[97]Ibid., p92.
[98]Ibid., p11.

whole discourse, unable to offer an opinion one way or the other on the figure of the ganja-smoker as they had previous to the enquiry been unaware that such a figure was believed to exist. So, for example in the summary of officials reports in Bombay it is noted that "most of the Superintendents of Jails write to say they have no experience as to the extent the abuse of ganja proves an incentive to crime, and few of them seem to have had their attention drawn to the subject",[99] while the Inspector-General of Police in Madras points out that "the Acting Commissioner of Police states that he cannot quote instances, as the subject has not hitherto received attention".[100]

Whatever the enquiry of 1871 shows about the differing opinions, and indeed the differing levels of awareness, of the figure of the user of hemp derivatives the Resolution which concluded the enquiry emphasized that the 'ganja-smoker' had been identified as a problem for colonial government in Indian society. The Government of India urged local governments to "endeavour, wherever it may be possible, to discourage the consumption of ganja and bhang by placing restrictions on their cultivation, preparation and retail, and imposing on their use as high a rate of duty as can be levied without inducing illicit practices"[101] and indeed in Burma the cultivation and consumption of ganja was absolutely prohibited from the beginning of the financial year 1873/4. Whatever the success of such measures and policy directives it seems that at the local level from the 1860s onwards the ganja-smoker had become a target of policing and surveillance:

> Many a man, reeling about the bazaar intoxicated with ganjah or spirit, finds himself, in coming to his senses, an inmate of a lunatic asylum.[102]

This is a process which accounts for case notes at the Lucknow asylum such as the following:

> Easeen Khan. Dementia. mussl. labourer. 32. 1 October 1861
>
> 1861 Oct. Sent in by City Magistrate, had been addicted to the use of ganja + on admission was suffering from its effects. As soon as these wore off, he appeared to be perfectly sane + on the 18th October was discharged.[103]

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[99]*British Parliamentary Papers*, p65.
[100]Ibid., p84.
[101]Ibid., p92.
[102]*Asylums in Bengal for the Year 1867*, p73.
[103]Case Book IA, patient no.134, admitted 1 October 1861.

The simple fact that he was known to be a regular user of hemp narcotics is the only reason given for his incarceration and there is not even any evidence of violent actions to call him to the attention of the authorities (indeed the dementia diagnosis may suggest that he had rendered himself insensible through the use of the drug).

Quite simply then, the figure of the ganja-smoker as violent, unpredictable, destructive and insane gradually became established in the last third of the nineteenth-century in the imagination of the colonizers in India to the extent that it had fed back into the metropolitan culture and so was the subject of Parliamentary questions in the 1890s. The significance of the production of this colonial knowledge is not simply that it is an example proving that the British were capable of generating understandings of Indian society because of their own systems and agendas. Rather, this knowledge directed power relations in the colonial encounter, as certain Indian practices and habits became demonised by the British authorities and certain Indian individuals became harassed and incarcerated.

Despite the fact that many used hemp derivatives to ease the pain of work, the harshness of life or simply to wile away the hours with no ill consequences, colonial government came to view the 'ganja-smoker' as a dangerous type in Indian society. It has been argued that this figure and the dangers associated with him were produced by the colonial project of mapping the Indian population, a project which was affected by the types of access that the government had to the Indian population. Limited to observing the Indian at specialist sites like the lunatic asylum the agendas of these institutions produced knowledge which they then acted, in their capacity as counting-houses, to translate into statistical representations which allowed their localized understandings of Indian society to be placed into the discourses of colonial government. In summary, general misgivings about intoxicants in British and certain Indian cultures, concern about wandering and seditious groups in the colonized society, Orientals constructions of the Indian etc. were crystallized at the asylum, at which various groups found blaming hemp use for various conditions an acceptable solution to their institutional and professional concerns, into a category or type of Indian through the processes of observing the Indian's body and behaviour. This category was then enumerated as the asylum filed annual statistical summaries into the colonial information gathering system, summaries which despite being based on doubtful evidence came to be quoted at the highest level in order to justify action. It would seem that the discourse on the ganja-smoker or hemp user is a classic example

of a colonial system producing, rather than simply recording, knowledge of a subject population and that the asylum was a key site in that productive process.

CHAPTER III.

Disciplining Populations: British admissions to 'Native Only' lunatic asylums.

CHAPTER III. DISCIPLINING POPULATIONS: BRITISH ADMISSIONS TO 'NATIVE ONLY' LUNATIC ASYLUMS.

Over the last thirty years there has been a concerted attempt to debase traditional histories of psychology and psychiatry.[1] These traditional histories are linked to the legitimation of those disciplines, as Nikolas Rose put it:

> Such authoritative texts of scientific history play a key role in constructing the image of the present reality of the discipline in question, a role which is indicated by the part they play in the training of every novitiate.[2]

Thus a conclusion like that of David Roberts, who asserts that "for centuries ... apathy had remained unchallenged, but when nineteenth-century humanitarianism joined with a more scientific understanding of insanity it diminished",[3] is complicit in the perpetuation of the myths which underlay asylum expansion in the nineteenth century and the development of the 'treatment' regimes within the new asylums.

Recent work on the history of the psycho-sciences and the institutions in which they developed has emphasised that rather than those sciences growing as a result of vague notions like 'humanitarianism' and 'enlightenment' they actually emerged from a relationship with the disciplinary projects of modern government. According to this work, the institutions functioned as detention centres for certain individuals who became incompatible with the emerging social order, in other words they served attempts to drill populations and societies by removing those who were inefficient and unproductive. The psycho-sciences developed in those asylums where the focus switched from disciplining populations to disciplining individuals. The unproductive and inefficient that had been weeded out were subjected to a variety of techniques designed to 'reform' them into useful individuals.

In both this chapter and Chapter IV this recent work will be examined in more detail and its relevance for understanding the asylum in the colonial context of British India will be determined. Here the ambitions of the British to drill the Indian population will

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[1]Authors targeted include Kathleen Jones (e.g.*A History of the Mental Health Services*, (Routledge London 1972)) and Norman Dain (e.g.*Concepts of Insanity in the United States*, (Rutgers University Press 1964)).

[2]N.Rose, 'Calculable minds and manageable individuals', in *History of Human Sciences* Vol.1, no.2, 1988.

[3]D.Roberts, *Victorian Origins of the British Welfare State*, (Yale University Press 1960), p63.

be considered while the following chapter will look at what was attempted in the colonial asylum by way of reforming the individuals incarcerated there.

The Psycho-sciences and Disciplining Populations.

One of the central myths of the older, more traditional historical accounts of the psycho-sciences is that there was a finite group of 'lunatics' awaiting discovery and that the identification of that group was governed by an objective, essential and unchanging standard.[4] Such an idea has been repeatedly challenged, and theoretical approaches to the question of changing meanings of madness throughout history have raised the issue of exactly who was being incarcerated in the asylums. Since Michel Foucault turned his attention to madness and the incarceration of those deemed insane in his work *Histoire de la Folie*, it has been a common theme in histories of policies dealing with the management of the mentally ill to relate the profile of those subjected by the power of the techniques of psychology and psychiatry to the cultural meta-narratives of the societies which formed the contexts for the emergence of those disciplines.

For example, Foucault maintained that those incarcerated in 'the Grand Confinement' of French history were victims of the cultural moment

> when madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group; the moment when madness began to rank among the problems of the city. The new meanings assigned to poverty, the importance given to the obligation to work, and all the ethical values that are linked to labor, ultimately determined the experience of madness and inflected its course.[5]

His conclusion was that by the mid-nineteenth century it was established that "the essential madness, and the really dangerous one, was that which rose from the lower depths of society".[6] This Foucauldian emphasis on "capitalism [as] a spirit that hovers over Western civilization"[7] and its importance as the meta-narrative which explains the asylum response to insanity is taken up in a number of studies. For example Nikolas Rose states that those who became the focus of the psychological disciplines in the

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[4]See A.Scull, *Museums of Madness: the social organisation of insanity in nineteenth-century England*, (Penguin 1982), pp234-253.
[5]M.Foucault, *Madness and Civilization: a history of insanity in the Age of Reason*, (Routledge London 1993), p64.
[6]Ibid., p260.
[7]D.Rothman, 'Social Control: the uses and abuses of the concept in the history of incarceration', in, S.Cohen and A.Scull (eds.), *Social Control and the State: historical and comparative essays*, (Blackwell Oxford 1985), p114.

nineteenth century were "the problems of the great cities",[8] those like vagrants or inebriates whose behaviour jarred with the imperatives of individual conduct and responsibility which underlay the capitalist political-economy of the nineteenth-century.[9]

The use of the asylum as a strategy and the target groups selected for incarceration were, says Andrew Scull, "intimately linked to a whole series of historically specific and closely inter-related changes in English society's political, economic and social structure; and to associated shifts in the intellectual and cultural horizons of the English bourgeoisie".[10] These changes and shifts issued forth from what he calls "the functional requirements of a market system",[11] and resulted in a set of anxieties about those who could not and would not work to which the asylum as an institution for the detention and correction of those considered deviant through their unfitness to work was one response.[12]

In such accounts then, the concern with poverty, desire to work and with the individual conduct of the labourer were anxieties which were born of the capitalist mode of production and which explain the type of individual, the pauper, the vagrant and the criminal, to be found incarcerated under the authority of the psycho-disciplines in the eighteenth and nineteenth centuries. Other accounts are available though which point to meta-narratives other than those of capitalism to explain asylum admissions. Elaine Showalter adopts a feminist perspective, and argues that women, who she points out formed a disproportionate amount of asylum inmates by the mid-nineteenth century, were being incarcerated in the context of the "patriarchal character of the Victorian age".[13] She concludes that

> in a society that not only perceived women as childlike, irrational and sexually unstable but also rendered them legally powerless and economically marginal, it is not surprising that they should have formed the greater part of the residual categories of deviance from which doctors drew a lucrative practice and the asylums much of their population.[14]

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[8]N.Rose, *The Psychological Complex: psychology, politics and society in England 1869-1939*, (Routledge London 1985), p52.
[9]N.Rose, *The Psychological Complex*, pp43-61.
[10]A.Scull, 'Humanitarianism or Control? Some observations on the historiography of Anglo-American psychiatry', in, S.Cohen and A.Scull (eds.), *Social Control and the State*, p126.
[11]A.Scull, *Museums of Madness*, p40.
[12]Ibid., pp18-48.
[13]E.Showalter, *The Female Malady: women, madness and English culture 1830-1980*, (Virago London 1987), p50.
[14]Ibid., p73.

Indeed, she emphasises how psycho-scientific justifications for controlling women grew more sophisticated and complicated towards the end of the nineteenth century to meet and contain the increasing agitation of women for greater access to power, noting that "medical and political policies were mutually reinforcing".[15]

Whatever the merit of such accounts, there is broad agreement on the theoretical premise that the psycho-sciences were in some way implicated in the processes of organising and managing populations and that the character of the incarcerated population in some ways reflects and relates to the cultural meta-narratives of the periods in which the asylums became established. This chapter will deal with the meta-narratives of colonial culture which determined the nature of the population in Indian asylums in the period 1859-1880.

Colonial Medicine and Disciplining Populations.

In the context of recent work on the place of medicine in colonial projects it would not be surprising at all if the asylums of British India, like those in Europe, should also have disciplinary functions. After all, this work on medical systems in colonial encounters emphasises that medicine, when exported from the West, was intended in many instances to serve colonial interests, to act to define and reform subject bodies and populations for the purposes of the colonizer.

The responses of Western colonisers to epidemic diseases and to matters of public health are well documented and vividly demonstrate the way that medicine acted to discipline or drill the peoples over whom power was being asserted. In Africa a number of studies demonstrate the impact of medical interventions in the face of epidemic disease,[16] and Megan Vaughan's example of the decisions made by the British doctor C.J.Baker in Uganda to deal with plague in 1920 seems fairly typical:

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[15]E.Showalter, *The Female Malady*, p73.

[16]See for example, H.Philips, 'The local state and public health reform in South Africa: Bloemfontein and the consequences of the Spanish flu epidemic of 1918', in *Journal of Southern African Studies*, 13, 1978, pp210-33; M.W.Swanson, 'The Sanitation Syndrome: bubonic plague and urban native policy in the Cape Colony, 1900-1909', in *Journal of African Studies*, 2, 1968, pp49-61; M.Lyons, 'Sleeping sickness, colonial medicine and imperialism: some connections in the Belgian Congo, in R.MacLeod and M.Lewis (eds.), *Disease, Medicine and Empire: perspectives on Western medicine and the experience of European expansion*, (Routledge London 1988), pp242-256; T.Ranger, 'The influenza pandemic in Southern Rhodesia: a crisis of comprehension', in D.Arnold (ed.), *Imperial Medicine and Indigenous Societies*, (Oxford University Press 1989), pp105-124 + pp172-188.

> He listed the following as preventive measures: the burning of infected houses (or disinfection in the case of brick-built houses in towns), the isolation of the sick, the segregation of contacts, inoculation of the population with Haffkine's prophylactic, distribution of information in the vernacular, and rat destruction.[17]

She goes on to detail the procedure that mass inoculations of the local commmunities took in this period. People were herded together and told to strip, examined by a doctor from head to toe and a number inscribed in chalk on the patients back to represent the dosage that he thought best. A leprosy doctor then examined each person and separated out the cases of leprosy. The patient was then sent into the treatment room, washed and had the area to be injected disinfected. The account that Vaughan is quoting from then details that

> the patient then passes to a bamboo 'lean' pole with his face to the wall. An assistant administers the prescribed dosage, as chalked on his back, deeply and intramuscularly into the upper and outer quadrant of the right buttock.[18]

In other words the colonial power forcibly and violently intervened in society, and took control of the local environment and the locals' bodies using medical techniques and medical justifications. People were separated from their communities, their houses were destroyed and even the chemical balance of their blood was altered using techniques advocated by Western medical experts and carried out to meet Western medical objectives. The local population was disciplined by colonial medicine to make their environment and their physiology more efficient in the colonisers' fight against diseases.

Similarly, epidemics were the occasion for the colonial authorities to intervene and rearrange Indian societies and bodies. Mark Harrison mentions the fact that concern about international commerce and the spread of disease lead to the British restricting Muslim pilgrimage from Madras in 1897,[19] and Roger Jeffery paints a picture familiar from African examples in describing the British reaction to plague in Western India in the 1890s:

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[17]M.Vaughan, *Curing their Ills:colonial power and African illness*, (Polity Cambridge 1991), p41.
[18]Ibid., p51.
[19]M.Harrison, *Public Health in British India: Anglo-Indian preventive medicine 1859-1914*, (Cambridge University Press 1994), p136; for policy on reorganising and interfering in Indian pilgrimages on medical grounds see R.Ramasubban, 'Imperial health in British India, 1857-1900', in R.MacLeod and M.Lewis (eds.), *Disease, Medicine and Empire*, pp44-45.

> The Bombay authorities took drastic action; sufferers were compulsorily removed to hospital, the infected were segregated, premises were evacuated, a sanitary cordon was attempted around affected areas, and travellers were medically inspected.[20]

In India as in Africa then, colonial authorities used medical technologies and medical imperatives to enter local societies and reorganise them forcibly. The same is the case even where the colonisers were not reacting to emergencies but were seeking to anticipate them, with programmes of preventive medicine. David Arnold focuses on vaccination against smallpox in India and quotes the Governor of Madras admitting that

> every life saved is additional revenue and an increase to the population and to the prosperity of the Company's territories in an incalculable ratio.[21]

In other words medical programmes were seen as an integral part of the colonial project of extracting profit from the colonies, in this case by preserving and propagating the workforce. By 1880 there was a Vaccination Act which made it compulsory for infants to receive the treatment with threats of fines for parents who did not comply. The bodies of the Indian population were being tampered with through medical procedures so as to prepare them, to drill them and arrange them to fit in with the objectives of the colonisers, as Arnold says:

> Given the critical importance of indigenous labour to the realisation of wealth from the colonies, *some* degree of medical intervention was clearly in the colonial interest.[22]

Other preventive measures centred around sanitation policies and public health measures. Such medical policies and measures acted to re-shape environments and police relationships within the colonial encounter to achieve the objectives of colonial projects. Accounts from Africa demonstrate the way that the logic of sanitation resulted in Europeans being physically separated in the urban environment from the local population, a separation that not only shaped the urban environment but regulated the types of relationships that Europeans could have with surrounding communities.[23]

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[20]R.Jeffery, *The Politics of Health in India*, (University of California London 1988), p98.

[21]D.Arnold, 'Smallpox and colonial medicine in nineteenth century India', in D.Arnold (ed.), *Imperial Medicine and Indigenous Societies*, p53.

[22]D.Arnold, 'Introduction', in ibid., p15; medical intervention to produce physiological states regarded as desirable for economic projects is also discussed in R.Sheridan, *Doctors and Slaves: a medical and demographic history of slavery in the British West Indies 1680-1834*, (Cambridge University Press 1985); L.Stewart, 'The Edge of Utility: slaves and smallpox in the early eighteenth century', in *Medical History*, 29, 1985, pp54-70.

[23]H.Deacon, 'Racial Segregation and Medical Discourse in nineteenth-century Cape Town', in *Journal of Southern African Studies*, 22, 2, June 1996, pp287-308; P.D.Curtin, 'Medical Knowledge and urban planning in tropical Africa', in *Amerian Historical Review*, 90, 1985, pp594-613; D.Headrick,

Such disciplining of social environments and relationships is also familiar from studies of India. Veena Oldenburg shows in Lucknow that even though the Europeans moved themselves away from the Indian town into a separate cantonment they still insisted on imposing changes on the Indian settlement in the name of public health.[24] This not only affected the appearance of the urban environment as wide open spaces to act as parks appeared where there were once houses and businesses and certain styles of architecture common to the cities of Northern India were prohibited as it was felt that they were unhygienic, but also disciplined the population to behave in certain ways and interact with their environment in a prescribed manner. Men were no longer allowed to urinate in the streets and could be fined heavily for not using the specially constructed latrines, and the city's Muslims were no longer allowed to bury their dead on sacred plots within the city. The local population had its ways of using the spaces of their own city restricted and limited by the British authorities in the name of medical requirements.

Medical legislation designed to prevent the spread of contagious diseases acted as a means of controlling the interaction between ordinary European troops and local women. Chatterjee argues that in defining who was to be regarded as a prostitute amongst Indian women who came into close contact with Western soldiers,

> the British administration ... wanted the definition to remain flexible so that any Indian woman whom the soldiers desired could be brought under the category.[25]

In other words, medical imperatives constructed the sexual relationship between ordinary Europeans serving as soldiers and local women as a purely commercial one, and made intimate encounters with those troops degrading and hazardous for Indian women. This served to police the boundaries between Europeans and Indians that the British authorities thought proper to the maintenance of their racial prestige, quite simply it limited the possible relationships between low-class European troops and low-status Indian women to an exploitative business transaction and made difficult the development of emotional attachments.

Overall then a number of accounts have demonstrated that Western medicine was implicated in the disciplinary projects of colonialism. Medical techniques were used to

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The Tentacles of Progress: technology transfer in the age of imperialism, 1850-1940, (Oxford University Press 1988), pp145-170.

[24]V.Oldenburg, *The Making of Colonial Lucknow, 1856-1877*, (Oxford University Press 1984), pp48-123.

[25]R.Chatterjee, *The Queens' Daughters: prostitutes as an outcast group in colonial India*, (Chr.Michelson Institute Bergen 1992), p9.

toughen and transform the bodies of colonised populations to prepare them for the tasks assigned them by colonial exploiters. Similarly medical expertise was called in to drill populations as a whole, and medical imperatives conditioned the ways that Indians and Africans interacted with their environment and the colonisers. The logic of Western medicine dictated and enforced ways for the populations and individuals that the colonisers encountered to move, work and live.

With its origins in the disciplinary projects of modern government in eighteenth and nineteenth century Europe and its links to medical services in the colonial system which have themselves been located within the disciplinary schemes of colonial government, the asylum is a key site for exploring the colonial projects of managing and drilling subject populations.

Routes into the asylum.

There were various routes by which an Indian could be admitted to a lunatic asylum in the period 1859-1880. The *Rules for the Management and Control of the Lunatic Asylum at Lucknow*, included in the published responses to Sir James Clark's enquiry into the treatment of lunatics in India give a fair summary of these routes.[26]

> The authorities empowered to order the admission of lunatics are:
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> *First*- Officers exercising the powers of a Magistrate, in respect of wandering or dangerous lunatics, or lunatics who are neglected or maltreated (Sections 4+5 of Act XXXVI of 1858).
>
> *Second*- Judges of the principal Civil Courts of Districts, in respect of all other lunatics except the two classes hereafter mentioned (Section 8 of Act XXXVI of 1858).
>
> *Third*- The Local Government as regards criminal lunatics (Sections 390, 394, 396 of the Criminal Procedure Code).
>
> *Fourth*- Military Officers commanding Divisions, in respect of native non-commissioned officers and soldiers afflicted with insanity (Section 41, page 291 Bengal Military Regulations).
>
> *Fifth*- The Inspector of Jails, as regards the removal of any lunatic from one public asylum to any other within the circle of his inspection (Section 11, Act XXXVI of 1858).

Elsewhere in the Rules there are further details provided about criminal lunatics.

> Persons confined under the provisions of Chapter XXVII of the Criminal Procedure Code, whether unsentenced but found guilty of the act charged (Section 394) or already sentenced (Section 396) or found unsound of mind on trial by the Court of Sessions (Section 389) or

[26]Home (Public) December 19 1868, 46-59A.

> deemed of unsound mind by the Magistrate after recording the examination of the Civil Surgeon of the district or some other Medical Officer (Section 388) shall be admitted into the asylum under the order of the Local Government to which the case shall be reported through the usual channel by the Magistrate or Court of Sessions, or other officer, as the case may be (Section 390+394).[27]

The distinction between the criminal lunatic and the lunatic admitted as neglected, dangerous or wandering is one that was central in asylum administration. The Lucknow rules state that "All criminal lunatics will be provided with a distinguishing dress, and will be confined apart from other lunatics in the enclosure and cells provided for them. Criminal male lunatics sentenced to rigorous imprisonment will wear a light iron ring on the left leg, and will be locked up at night". Dr. Corbyn at the Bareilly asylum mentioned that "Criminal Lunatics are of course kept apart from the others, and have a yard and ward exclusively their own".[28] It is not always clear that distinguishing dress, leg irons and spatial separation were enforced in other asylums, but by the 1860s the criminal lunatic as a separate subgroup of the asylum population was recognised throughout the asylums of British India as shown in the annually published reports supplied by the superintendents of each asylum, where a count of the criminal lunatics was routinely provided for each asylum, often with further statistics regarding their crimes, their marital status and so on. This division, between the criminal and the non-criminal will initially be followed here.

The non-Criminal Lunatics.

Act XXXVI of 1858 governed the admission of non-criminal lunatics into the asylums of British India.[29] It stated in Clause IV that

> it shall be the duty of every Darogah or District Police Officer to apprehend and send to the Magistrate all persons found wandering at large within his district who are deemed to be Lunatics and all persons believed to be dangerous by reasons of Lunacy. Whenever any such person as aforesaid is brought before a Magistrate, the Magistrate, with the assistance of a Medical Officer, shall examine such person, and if the Medical Officer shall sign a certificate in the Form A in the schedule to this Act, and the Magistrate shall be satisfied on personal examination or other proof that such person is a Lunatic and a proper person to be detained under care and treatment, he shall make an order for such Lunatic to be received into the Asylum established for that Division ...

and established in Clause V that

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[27]Home (Public) December 19 1868, 51A.
[28]'Annual Reports of the Lunatic Asylums at Bareilly and Benares for the year 1867', in *Selections from the Records of the Government of the North-Western Provinces*, p59.
[29]See Appendix II.

> if it shall appear to the Magistrate, on the report of a Police Officer or the information of any other person, that any person within the limits of his jurisdiction deemed to be a Lunatic is not under proper care and control, or is cruelly treated or neglected by any relative or other person having the charge of him, the Magistrate may send for the supposed Lunatic and summon such relative or other person as has or ought to have the charge of him ... If there be no person legally bound to maintain the supposed Lunatic, or if the Magistrate thinks fit so to do, he may proceed as prescribed in the last preceding Section ...[30]

Wanderers, the dangerous and the neglected were the targets of this legislation although there is evidence that the asylums and the authorities subsequently refined this. It is doubtful if the Police regularly concerned themselves with the treatment of the insane in Indian homes, as Dr. Simpson of the Dacca asylum wrote in 1862: "With Native Police this section becomes null and void".[31] There is no evidence in the whole of the Lucknow case notes of a patient having been admitted as a result of poor treatment by his/her family becoming the concern of the authorities, and indeed there are case notes such as the following which suggest the opposite.

> Allo Rukee (f). Dementia. 26. Mussl. Beggar. 7th February/65.
>
> 7th February 1865. Sent in by City Magistrate of Lucknow.
>
> 2nd April 1865. This appears to be a case of melancholy mania probably the effects of bad treatment at home. No improvement whatever.
>
> 29th August 1865. Made over to her husband much improved.[32]

That she is dismissed as 'much improved' rather than with the more common 'discharged, cured' would suggest that the medical officer writing the report still considered her less than completely free of the symptoms which had led to the original diagnosis but was looking for a satisfactory formulation to justify releasing a harmless but disordered and demoralised woman. Significantly though, he is releasing her back to the very family which it was reckoned had treated her so poorly, in other words this would appear to be an example of a process which was the exact reverse of that which it was deemed desirable in law to follow: a lunatic is being released back into a family which it is felt neglects her.

Indeed, notes of concern in official correspondence in the 1860s suggest that this was not just the case in Lucknow and that elsewhere the authorities were failing to implement the part of the act relating to maltreated lunatics in Indian homes. For

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[30]W.Theobald, *The Legislative Acts of the Governor-General of India in Council*, (Calcutta 1868).
[31]*Annual Report of the Insane Asylums in Bengal for the Year 1862*, p34.
[32]Case Book II, patient no.151, admitted 7 February 1865.

example, some ten years after the Act the opinion of the superintendent of Moydapore in Bengal was being reproduced in official correspondence:

> It is I think, allowed by all who have any intimate knowledge of the village population of this country that the number of lunatics in our asylums represents a very small proportion of that unfortunate class to be found in every district; and that the vastly larger proportion is kept at home and supposed to be taken care of by their relatives; but this care consists of a degree of severity towards them, especially if they have the least tendency to be obstreperous.[33]

The filtering into asylums of those insanes neglected in their homes envisaged by the 1858 Act seems largely to have been forgotten or sidelined in the admission of non-criminal lunatics. By far the largest proportion of this group was made up by what can be termed public order offenders: the wanderers and the dangerous.

The Wanderers.

Take for example the first admissions in the second volume of case notes. Of the seven patients admitted at the beginning of 1863 (period 8 January to 12 February) five had been admitted because they had been found in the act of 'wandering'. So for example:

> Gosalee. Maniah. 28. Hindoo. Beggar. 8th Jan' 63.
>
> Sent in by City Mag. of Lucknow found knocking about the city calls himself 'Moonshie Ram Dyal'. Is very wild and displays much excitement and general incoherence in making replies to questions.
>
> June 1863. Died of chronic diarrhoea.[34]

A month later there is

> Ram Deen. Mania. 35. Hindoo. Kapoor. 12th Feby/63.
>
> Sent in by Cantonment Magistrate- was found wandering about Suddur Bazar at night. He talks + mutters very great nonsense, is apparently harmless.
>
> 1864. This man was never in the enjoyment of good health. Always looked sickly + did not improve in his mental condition about 6 weeks ago he began to suffer from Diarrhoea- it gradually reduced him + became intractable. Died on 14th July 1864.[35]

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[33]Gvt.Ben. to GOI 21 July 1868 in Home (Public) 8 August 1868, 56-59A.
[34]Case Book II, patient no.1, admitted 8 January 1863.
[35]Case Book II, patient no.7, admitted 12 February 1863.

Such admissions are typical throughout the period for which case notes are available. A year before in 1862 there is the case of Allee Jaim.

> Allee Jaim. Mania. Mussl. Beggar. 40. 19 Feby 1862.
>
> Feb 1812. This man was sent in by City Magistrate of Lucknow- he had been taken up by Police as a beggar- whether from want or dissipation he appears to be weak in intellect and is so reduced in flesh + natural vigour that it is evident he has not long to live. Suffered from diarrhoea ever since admission- gradually got weaker + died 25th March 1862.[36]

Indeed, entries still read like this in the following decade:

> Mosst. Khunnia. Chronic Mania. 23. Hindoo. Labour. 29th April 1870.
> Certified by the magistrate 'not violent'.
>
> 1870 April 29. Sent in from Roy Bareilly- has been wandering about that district for years picking up her living how she could, she appears a harmless, quiet individual.[37]

The asylum as a receptacle for the vagrant was part of a wider set of social policies in British India aimed at controlling and policing the Indian population. These policies sprang from two sets of anxieties, those of modern government systems in general and those born of the colonial experience of governing.

European forms of government had identified vagrants and vagrant groups as a threat from the fifteenth-century onwards and had occupied themselves with disciplining them. Jütte points out that

> vagrancy was a socially defined offence which reflects the dual problem of geographical and social mobility in early modern Europe. Offenders were arrested and punished not because of their actions, but because of their marginal position in society. The implication was that vagrants were no ordinary criminals; they were regarded as a major threat to society, and therefore pursued by all authorities and stigmatized as deviants.[38]

In England the vagrant had a central place in the demonology of popular culture[39] and became a focus of early governmental social legislation. As early as 1383 there was a law enabling local justices and sheriffs to detain and deal with vagabonds in their areas, and the series of Poor Laws established in the reign of Elizabeth I set about

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[36]Case Book IA, patient no.168, admitted 19 February 1862.
[37]Case Book IV, patient no.186, admitted 29 April 1870.
[38]R.Jütte, *Poverty and Deviance in Early Modern Europe*, (Cambridge University Press 1994), p147.
[39]See G.Salgado, *The Elizabethan Underworld*, (J.Dent London 1977), chapters 6, 7, 10.

going beyond the notion of simply punishing the vagrant and established a principle of settlement and compulsory employment.[40]

By the nineteenth century in Britain the vagrant was viewed as an incontrovertible 'social danger' for whom special severity was reserved by the penal system[41]. Nikolas Rose suggests that this was because, to the authorities of the period,

> pauperism was a rejection of regular employment which meant also an existence outside the benign self-regulating mechanisms of the economy ... a refusal of all those relations which were so essential to a healthy, wealthy and well-ordered polity.[42]

If the vagrant-as-customary-concern-of-Western-forms-of-government idea partially explains why the British should focus on the Indian itinerant when they exported those forms of government to Asia it does do only that. As suggested earlier there were anxieties peculiar to the Europeans in India which need to be taken into consideration when explaining the direct action taken against vagrants.

Veena Oldenburg focuses on the British perceptions of Indian cities in *The Making of Colonial Lucknow* and shows how they were behind the spatial reorganisation of the city in the 1860s and 1870s. She quotes Europeans during the 1850s describing "vast multitudes of people parading backwards and forwards, on horseback, in palkies and on foot",[43] and deciding that in its "narrow but picturesque street bazaars ... the population was literally 'teeming' so that it was impossible to ride or even drive in the streets save at a walk".[44] It is important to note the emphasis in these impressions, as what the Europeans conjure up is an image of unfathomable mobility and their perceptions of restlessness and insect-like 'teeming'. Such a volume of people, constantly moving around through narrow and unplanned alleyways and streets, was experienced as a threat by the numerically tiny European population. This fear was reflected, says Oldenburg, in the overestimation of the population by the British. From the 1850s it was held in the colonial imagination that the city must be at least a million strong, a figure which was still present in newspaper reports in 1867 despite an official estimate of the population at about 300 000.[45] These perceptions of the Indian population as a teeming, threatening swarm were only heightened by the

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[40]P.Slack, *Poverty and Policy in Tudor and Stuart England*, (Longman London 1988), pp113-131.
[41]D.Garland, *Punishment and Welfare: a history of penal strategies*, (Gower Aldershot 1985), p64.
[42]N.Rose, *The psychological complex*, p45.
[43]Mrs.Meer Hasan Ali in V.Oldenburg, *The Making of Colonial Lucknow 1856-1877*, (Oxford University Press 1989), p18.
[44]G.H.Rouse in ibid.
[45]Ibid., pp18-19.

experiences of the 'Mutiny' of 1857/8, when "hordes of unemployed and desperate men roamed the city for food or treasure, and bands of soldiers plundered and terrorised those inhabitants who had not fled into the countryside for safety".[46]

The city, and indeed much of Northern India, had proven beyond the command of the British because they had been unable to monitor and check the movements of the Indian population. Once power was regained then a number of measures were taken to remedy this lack of control. The most dramatic was probably the large-scale reconstruction projects. The British undertook to alter the physical environments of the cities so as to render the movements of the Indian population subject to their scrutiny. Oldenburg shows how before the reconstruction

> streets served principally as areas where people milled, mingled, and socialised, where itinerant hawkers lined the curbs, where goods and services were bought and sold ... The street was a public space with social and recreational functions. In Lucknow the custom was often to go to the street not to get anywhere; the street itself was a destination and an event.[47]

This situation produced crowds and constant movement and meeting, a situation which put the streets and the population beyond the control of the colonials. So much of the old system of winding alleys, dead-end lanes and cramped bazaars was demolished and replaced by broad, straight boulevards, flanked by uniform rows of shops and punctuated with police posts and barracks. This was an attempt to "reduce the seeming chaos",[48] which the British felt around them, it was all part of a strategy to render the movements of the Indian population the subject of colonial surveillance and control. This was a pattern that dominated in many of the cities under British dominion after 1858: "the dynamics that transformed Lucknow were also at work in other pre-colonial cities ... the era of reconstruction in Lucknow therefore serves as a paradigm for the understanding of urbanisation in the mid-nineteenth century colonial setting".[49] Indeed King in his study of Delhi notes the importance of the period after 1857 for the spatial reorganisation of the city: "New roads were laid out: Hamilton Road, slicing off the northern area of the city; Queen's Road, running parallel and north of the 'Queen's Gardens'; Lothian Road running north-east from Kashmiri Gate to the Fort; Elgin Road cutting straight across the Fort to join up with Daryaganj;

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[46]V.Oldenburg, *The Making of Colonial Lucknow*, p64.
[47]Ibid., p39.
[48]Ibid., p40.
[49]Ibid., preface pp.xvii-xviii.

Nicholson Road, marking the southern extremity of the occupied area; Esplanade Road, typically dividing the military zone from the area of indigenous occupation".[50]

The anxieties which originated in the experience of living in uncontrollable cities which had risen against them had resulted in a determination on the part of the British colonials to control the movements of the Indian population. One approach then, was to reorganise the physical structure of cities, to control the movement of the urban masses by rendering them predictable and visible. The people of the city would have to move around in ways prescribed by the colonial authorities and which made them the subjects of the colonial gaze. The social corollary of the spatial reorganisation of the cities was the various measures aimed at limiting the freedom of movement available to Indians.

Some localised attempts to restrict the movements of wandering groups were mentioned in the previous chapter but there were major schemes devised, and pieces of colonial legislation passed, in this period which attempted to deal with mobile groups. The experience in Northern India, where "the measures adopted in Punjab closely followed surveillance methods practised in the NWP where the district governments had used a variety of expedients to control vagrant groups",[51] eventually lead to the Criminal Tribes Act of 1871 which originally applied just in the North-Western Provinces, the Punjab and Oudh.[52] Provisions included having suspect tribes register themselves in fixed places and necessitated their possessing a license before moving. Again then, the emphasis was on surveillance and restriction of movement to render these groups visible and predictable.

There was also the problem of individual vagrants though, part of the "riff-raff"[53] perceived to move through Indian society and who were considered "dangerous as well as criminal"[54] but to whom the Criminal Tribes Act was not applicable. One response to this problem was Section 295 of the Criminal Procedure Code.

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[50]A.King, *Colonial Urban Development: culture, social power and environment*, (Routledge London 1976), p214.
[51]Sanjay Nigam, 'Disciplining and policing the 'criminals' by birth, Part I: the making of a colonial stereotype; the criminal tribes of North India', in *IESHR* vol.XXVII, no.2 1990, p137.
[52]M.Radhakrishna, 'The Criminal Tribes Act in Madras Presidency: implications for itinerant trading communities', in, *IESHR* vol.XXVI, no.3 1989, p271.
[53]D.Arnold, 'Crime and Crime Control in Madras, 1858-1947', in A.Yang (ed.), *Crime and Criminality in British India* (University of Arizona Press 1985), p85.
[54]Ibid.

> Whenever it shall appear to the Magistrate of the District or to an officer exercising the powers of a Magistrate that any person is lurking within his jurisdiction not having any ostensible means of subsistence, or who cannot give a satisfactory account of himself, it shall be competent to such Magistrate or other officers as aforesaid to require security for the good behaviour of such person for a period not exceeding six months.[55]

Failure to provide security would result in imprisonment, although from the criminal statistics available it is difficult to work out exactly how often imprisonment for vagrancy occurred under this section.[56] Examples like that of the Barwars in Oudh do show however that imprisonment was used as a solution to the mobility of the Indian population. The Chief Commissioner noted that he had

> received a petition from some Barwars complaining of the persecution they are subjected to, and asserting that two hundred of their caste-men, being a very large proportion of the males of the tribe, are undergoing imprisonment without having been convicted of any special offence under the Penal Code.[57]

He explained that this group, "by tradition worship a deity of theft" and "that they are of roving habits",[58] although he did admit that the system of illegal detention seemed like "a mode of indiscriminate terrorism"[59] on the part of the district authorities. These people were not members of a British classified wandering tribe, rather they had become linked in the British imagination with a deity of theft and so even if they were "industrious and have business at fairs and such places"[60] they were regarded with suspicion and so members were picked up and incarcerated while travelling with very little legal justification.

It is in this context then that the non-criminal lunatic admission should be understood. Admission into a lunatic asylum was one of the strategies devised by the colonial authorities for containing what they perceived as the wanton and dangerous mobility of elements of Indian society. The asylum and the prison in conjunction with laws like Section 295 of the Criminal Procedure Code and Act XXXVI of 1858 and indeed with non-legal detention were all in the range of institutional solutions to individual

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[55]*The Code of Criminal Procedure: An Act passed by the Legislative Council of India on the 5th September 1861*, (W.H.Allen London 1862), Section 295.
[56]Security could be taken for other offences as well such as 'bad livelihood' and the total defaulters imprisoned is recorded in the various Judicial (Criminal) statistical tables rather than by section under which committed.
[57]*Report on the Administration of Criminal Justice in Oudh for the year 1880*, p7.
[58]Ibid., p6.
[59]Ibid.
[60]Ibid.

vagrancy. Apart from the asylum or the prison, vagrants could end up in the idiot ward, the hospitals and dispensaries or local poor houses.[61]

In various towns there was accommodation made available for those classified as idiots. In the Bombay Presidency for example, there was a scheme "to rent a small house for the accommodation of the many troublesome idiots in Belgaum",[62] and the Government sanctioned "a shed for some harmless idiots who for a long time have been at the Dispensary"[63] in Rae Bareli in Oudh. These were attempts to get round the "instructions of the Government of India interdicting the practice of sending incurable and harmless idiots to the Lunatic Asylum"[64] on the grounds that it "does not seem desirable in any way to increase unnecessarily the charges upon the State for Lunatic Asylums".[65] Indeed the priorities of those governing in the localities gradually overcame the financial imperatives of the central administrators to the point that these orders were overtly ignored. Because it was pointed out that "the district authorities naturally find it difficult to take care of harmless idiots found wandering about without any means of subsistence and whose relatives cannot be found", the Chief Commissioner of Oudh went ahead and

> sanctioned the construction of three barracks in the enclosure of the Lunatic Asylum to provide for the accommodation of twenty-four male and twelve female idiots. These buildings will be constructed from provincial funds, but the charge for the care and maintenance of each idiot will be borne by the local funds of the district from which the idiot was sent to the asylum.[66]

Indeed, such was the concern to have wanderers tucked away safely in some institution that the different criteria for admitting a person into the various institutions seem so difficult to discern that it can often be doubted that separate sets of criteria existed. In other words a vagrant would not necessarily need to be an idiot to end up in an idiot ward, a criminal to end up in a prison or a lunatic to end up in an asylum. It was enough to be an itinerant to qualify for eligibility for admission into whatever local institution had spaces available. There are examples like that of Maharanee where, despite a number of crimes having been committed, the vagrant is just bundled into the

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[61]There appears to have been one such in Lucknow. Various case notes refer to the transfer of inmates to/from this institution to/from the Asylum. See for example Lum Boor (Case Book IV, patient no.6, admitted 17 October 1868) "transferred by order of visitors to the poor house" or Buslee (Case Book IA, patient no.25, admitted 29 May 1860) "admitted from almshouse, is perfectly idiotic but happy".

[62]Extract from Gvt.Bom.(General) 26 Feb 1869 in Home (Public) 27 March 1869, 4-5A,

[63]Oudh (General) 8 September 1875, 231-232B. Notice the mention here of the district hospital facilities as a solution to the needs for institutional provision for local vagrants.

[64]Oudh (General) 1 July 1874, 36B.

[65]Order 3 February 1873 in Home (Public) June 1873, 78-79A.

[66]Oudh (General) 19 July 1976, 430B.

asylum out of harm's way rather than dragged through the legal system and sentenced to prison.

Maharanee (f). Mania. Mussl. Beggar. 35. 25 Novr. 1861.

> 1861 Novr. This woman was sent into the Asylum by the Dy.Commr. of Nawabgunge, Barabunkee- no history of her case is obtainable, her antecedents are quite unknown. She was picked up on the road, after having entered a house, abused the inmates + smashed sundry articles of pottery- her name even was unknown: till after her admission + whether she gave a correct one is impossible to say. She is very weak, suffers from diarrhoea + talks with great volubility. She never gave indications of much intelligence, gradually became weaker, lost her appetite- diarrhoea became intractable + on March 30th 1862 she died.[67]

Similarly there are examples of vagrants, having been detained by the police, becoming entangled in the system with noone accepting responsibility for them or knowing what to do with them as they are passed on by various authorities until a place is finally found for them.

Angnoo. Dementia. Hindoo. Barber. 25. 14 October 1861

> 1861.Sent in by police. His papers were irregular and returned to City Magistrate for correction, but they were never received.
>
> He had been picked up in the district + forwarded from thannah to thannah until brought to the asylum. He was in very low state of health, scarcely ate any food + could with difficulty be managed. He had diarrhoea or fever which improved by good food. During the cold weather however, it returned + became quite intractable. Died 26th March 1862.[68]

There are even instances which show detainees being juggled between institutions unwilling to accept individuals forced upon them by the policy of incarcerating wanderers.

Punchum. Mania. Hindoo. Faqueer. 60. 27th Novr.

> 1861 Nov. This man was admitted from City Hospital. He was brought there by the Police and no history of his case was procurable. Was in a very weakly state. Was quite unable to take food + died 2nd Dec. 1860.[69]

These are full reproductions of the individual records. What they show is that little consideration is given to whether the people admitted are insane or not, there is no evidence of the process of diagnosis and no record of symptoms supposed to demonstrate insanity. Indeed what they do show is less the admission of lunatics and

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[67]Case Book IA, patient no.153, admitted 25 November 1861.

[68]Case Book IA, patient no.140, admitted 14 October 1861.

[69]Case Book IA, patient no.95, admitted 27 November 1861 (in the original volume this case note was not numbered and appeared in the pages relating to admissions of April 1861).

more the incarceration of people physiologically weakened by the harsh experiences of living rough. These examples provide a glimpse of a system which primarily concerned itself with arresting population movements considered unjustified or undesirable in the context of the overriding goal of preserving order and which then dealt with the problem of what to do with the individuals detained by shuffling them between the available institutions. This process was justified by reference to the legal excuses provided in legislation like the Code of Criminal Procedure and Act XXXVI of 1858. With the lunatic asylums, this would suggest that vagrancy was very often sufficient to qualify an individual to be classified as insane. Section 295 of the Criminal Procedure Code stated that its object was the individual who had no obvious means of subsistence and he/she "who cannot give a satisfactory account of himself". Consider examples such as that of Kirmuhia

Kirmuhia. Dementia. Koree. Labour. 30. 1st November 1860

Novr. Sent by Mr. Bicken AC, had been for several days hanging about the Treasury without being able to give any account of himself. He appeared to derive immense pleasure at the sight of glittering rupees + appeared annoyed at the crowd of people who resorted to the Treasury. On admission is quiet + taciturn, can give no satisfactory account of himself.

1861 Jany. Is quiet + well conducted. Obedient to orders + makes himself useful in the garden. Nothing has transpired regarding his previous history.

June. Has been suffering from diarrhoea for a long time past, got gradually weaker + on 29th June died.[70]

The significance of this case note is the reproduction of the language of Section 295. This mirroring of the requirement phrased in the Section as the need to "give a satisfactory account of himself" is intriguing and suggests that the circumstances of the admission are closely related to the concern of Section 295 to give the authorities the power to detain vagrants. Indeed this use of the phrase recurs throughout the case notes in examples like Jookeea.

Jookeea (f\. Mania. 20. Hindoo. Beggar. 10th Sept/62.

1862. Sent in by City Magistrate of Lucknow was found wandering about the streets, could give no account of herself, is young and good-looking. Appears to be suffering from weakness of intellect, gives very brief + often incoherent and absurd replies to questions- is very tractable.

1865 March. Somewhat improved since admission. Looks happier + talks sensibly, occupies herself a little in spinning.[71]

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[70]Case Book IA, patient no.66, admitted 1 November 1860.
[71]Case Book IA, patient no.226, admitted 10 September 1962.

Look at the details in this case. A frightened young woman who has ended up without a home and family for whatever reason is challenged by the police. In her anxiety and confusion she clams up and her answers therefore seem brief and incoherent to the white male of whom she is naturally fearful. With the knowledge that, as a vagrant, she will have to be detained somewhere and as her reluctance to answer vaguely qualifies her for one of the diagnoses of which he is aware, the British doctor decides she is weak of intellect and agrees to have her admitted.

If this is rather filling in the gaps in the notes it is undeniable that very little in her record, or indeed in others like Kirmuhia above who share the pointed entry on their notes of being unable to account for themselves, suggests obvious eccentricity or 'insanity' in the patients. It would seem that the criteria which these individuals have fulfilled are not those of insanity but those of Section 295, that is by refusing to disclose what they were doing and where they were from, they became classified as an object of concern to the authorities as vagrants. The language of the case notes reflects this. In these instances they were found lodging in the asylum to keep them off the streets. It appears then that the state of vagrancy often led to an individual being accused of the state of insanity.

It was the anxiety of modern colonial government about the movements of the Indian public and the concomitant concern to control the movements of the Indian population which ultimately explains the preoccupation of Indian legislation on lunatics focusing on 'wanderers' and to their incarceration in lunatic asylums. It was similar concerns which led to the legislative sanction to admission into asylums of those considered 'dangerous' because of their lunacy.

The Dangerous.

It is difficult to discover the details of behaviour in most of the cases admitted as 'violent' or 'dangerous' as they usually read like that of Nuncoo.

> Nuncoo. Dementia. 26. Hindoo. Cultivator. 25 June/64.
>
> 25 June 1864. Sent in by Deputy Commr. of Baraitch.
>
> 25 March 1865. She remains a violent lunatic + is in no respect improved.
>
> 26th August 1866. Died of chronic diarrhoea.[72]

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[72]Case Book II, patient no.113, admitted 25 June 1864.

With so little information about such admissions it is difficult to ascertain what type of behaviour lead to her original incarceration. If wildly disruptive and aggressive, the only information that we have about her is that she was permanently so. Some admissions do, however, have more information available for them. A contrast to the above example is that of Jewbodh Koomar.

~~Amentia-~~ Mania ~~aeute~~ chronic. Jeobodh Koomar. 28. Hindoo. Daily Labourer. 27th Feb. 1869.
Certified by Magistrate Violent.

27th Feb/69. Sent in by the Magistrate of Fyzabad, there is no previous history of this man's health and habits- he appears to me to be a very excitable idiot, that may prove violent and even dangerous at times- his habits are very filthy. The Civil Surgeon of Fyzabad certified 22 Feb. 1869, 'Jeobodh sits in his cell occasionally beating himself against the wall. Dirty in habits. Smears himself over with his faeces, general aspect that of a maniac. Said to attempt to bite all who approach him. Will not always speak + when does, gives incoherent answers. Does not eat unless fed'.

1st June 1872. A congenital idiot- no improvement.
10th Feby 1873. Just the same as last report.

Oct 11. This man has attained excellence in durrie weaving. He is very industrious.

1878 Aug 1st. He has a scar on his forehead. When asked how he got mark he said, 'When I was working in field'. He is now in a great rage, and utters every kind of abuse in a furious manner. 'Everybody knows my name Jeobodh as a man who can do everything. God made me stand upright'. He refers in a loud, screaming voice + extreme anger to my having put him into a bag for violence. When I smiled he said as much as, 'Go on laugh, I will make you cry'.

They say he is never violent except when he sees Europeans though sometimes he gets angry. He has not been so angry for a very long time. They say he sometimes gets abortive attacks of epilepsy. The Hosp. Asst. has not seen them.

1884 March 29. Continues to get excited. Works well- General health good.
1888 June 11. Is in poor health.

17 June. Is satisfied to remain where he is. He works regularly and there is no change in his condition.

1889 14 April. Is very quiet and has lately been attending to the cows. He is thin and suffers dysentery. Ordered 2 chittacks meat and 1/2 oz. ghee.

5 Aug. Is now in good condition. Extra food is stopped. Is mentally the same.

1893 15 Jan. So often excited and noisy. Gets milk. In fair condition. Weighs 108 lbs.

May 1895. Suffers from periodic attacks of mania which last for about a week. In the intervals he works in the weaving factory. General health fair. Weight 102, 6lbs. less than when last weighed. Is given a little more extra food.

May 1895. This man has been losing weight; now 94lbs. Gets extra diet. Mental condition the same.

March 1896. Old and decrepit- has been in hospital for neuralgia of stomach since 19 Jan. 1896.[73]

It is worth quoting the entire length of this case as it provides a rounded picture of the 'dangerous' lunatic which concerned the British. The overall tone seems to point to the fact that this man was subject to occasional temporary rages, which even resembled epileptic fits at times such was their intensity. He first came to the attention of the authorities when he was brought to the Civil Surgeon of Fyzabad during one of his fits, but seems to have calmed down sufficiently by the time the superintendent of the asylum wrote his first report for the author to dissent with the opinion of the Civil Surgeon's diagnosis of mania. The superintendent had obviously seen him calm enough to decide that he was only 'dangerous at times' and to be no more than an excitable simpleton. The patient proves over time more than capable of settled living during the intervals between fits, able to look after livestock and even learn a new skill. The point is that he is kept in the asylum, presumably until his death (which is not noted), because of his *potential* for violence. He is not permanently furious or aggressive, but the authorities fear the latent danger he represents. Especially as it transpires that it is feared that this violence would be aimed at Europeans.

The incarceration of those with the potential for violence is evident in other case notes.

Bholai. Chronic Mania. 40. Ahir. Cult. 9th Feby. 1869.
Certified magistrate-violent/dangerous, throws bricks at people.

9th Feby 1869. Bholai admitted for first time. Is said to be occasionally very violent and filthy. To be kept with the violent lunatics- sent in by Magistrate of Sultanpoor.[74]

And also in inmates admitted throughout the period:

Subnee. Mania. Hindoo. Beggar. 25. 21 October.

1861. Sent by Police from Mumarra. Was very wild and excited, is subject to occasional attacks of greater severity. Generally quiet and well-behaved- spins- appears to have no friends and no enquiries have ever been made after her.

1866. Died of debility on 1st September 1866.[75]

These patients were all subject to occasional, intense and temporary paroxysms of intense and aggressive behaviour. It seems then that the British used their asylums not

[73]Case Book IV, patient no.42, admitted 27 February 1869.
[74]Case Book IV, patient no.32, admitted 9 February 1869.
[75]Case Book IA, patient no.148, admitted 21 October 1861.

only to incarcerate those who were a permanent danger by way of their constant aggression and ongoing extreme behaviour, but those who although usually perfectly 'quiet and well-behaved' represented a future threat to public order as they had demonstrated a potential for sudden, very physical, fury.

Removing such people from Indian society can all be seen in the context of policies aimed at rendering the Indian population docile, they are all part of the period when "the Indian people were being systematically disarmed".[76] This description is usually taken to refer to the disarming operations undertaken under the Arms Acts XXVIII of 1857 and XXXI of 1860. The more extreme measures of the first act legitimised searching out and confiscating weapons, and even the second, less stringent act, authorised the disarming of all whom the Magistrate considered "a danger to the public peace".[77]

These measures were the result of the anxieties of colonial rulers facing a largely unknown and unknowable human mass, a mass which after the 'Mutiny' of 1857 the British imagined had proven its capacity for sudden, unpredictable violence. The incarceration of 'dangerous lunatics' in asylums should then be seen in this context of disarming the Indian people and the anxieties which lay behind it. The British were eager to take whatever steps they could to limit the threats that the Indian population could present, and this meant doing anything from taking weapons away from Indians to actually removing potentially dangerous and unpredictable individuals from society to limit the violent surprises that the indigenous communities could throw at British order. Thus those who had proven themselves even occasionally aggressive or disordered were detained in asylums to reduce the potential dangers which the British feared they faced.

The British attempted the legitimation of their non-criminal lunatic admission policies by claiming humanitarian motives. "It is refreshing to think that the condition of insanes of this country attracts so much attention; for there is no doubt that their condition was very miserable, and that they were much neglected",[78] opined J.Penny, the superintendent of the asylum at Delhi. This tactic is familiar. What Foucault calls the image of "the confrontation of the wise, firm philanthropist and the paralytic monster",[79] is dismissed as a powerful myth in his revision of the role of Tuke and

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[76]D.Hardiman (ed.), *Peasant Resistance in India 1858-1914*, (Oxford University Press 1993), p1.
[77]T.Metcalf, *The Aftermath of Revolt: India 1857-1870*, (Princeton 1965), p305.
[78]*Annual Report of the Lunatic Asylums of the Punjab for the year 1871-2*, p6.
[79]M.Foucault, *Madness and Civilization*, p242.

Pinel, those pioneers of asylum administration, and he points out that "beneath the myths themselves, there was an operation, or rather a series of operations, which silently organised the world of the asylum".[80]

Beneath the humanitarian myth in this Indian study then, lies not just operations designed to organise the world of the asylum, but operations directed to the organising of the colonial world as a whole. The incarceration of the non-criminal Indian lunatic was one of the many strategies devised by the authorities during this period to control the Indian population and to limit its potential for disorder. To a certain extent, what lay behind this range of disciplinary techniques, from incarceration of vagrants to the licensing of tribal group movements, lay the meta-narratives of modern governmental anxieties familiar from the metropolitan experience: "The ideology sustaining the notion of 'criminal tribes' was not wholly a product of the colonial environment. Even in Victorian Britain the government feared the so called 'dangerous classes', who were conceived of as threatening public order".[81]

What has been established though, is that there was a peculiarly colonial narrative surrounding these strategies, right down to the admission of a wandering pauper into a lunatic asylum. This was the essential insecurity of the European community which, especially after 1857, determined the disarmament of the Indian population, the reconfiguration of physical spaces to segregate Indians from Europeans[82] and indeed the reconfiguration of social and cultural spaces to enforce the distance of Indians from their colonisers.[83] Those admitted to the asylum were those whose lives seemed to represent to the British what they feared most in the Indian population; mobility and unfathomable unpredictability became 'wandering' and 'dangerous' on the case notes of the individuals in the asylum. It must be remembered though that the asylum was only one of a range of measures, some planned at government level like the Criminal Tribes Act, some improvised at the local level like an 'idiot ward' or a Poor House, which the colonisers devised to deal with such embodiments of their anxieties.

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[80]M.Foucault, *Madness and Civilization*, p243.
[81]T.Metcalf, *Ideologies of the Raj*, (Cambridge University Press 1994), p124.
[82]On the segregation of Europeans in cantonments see A.King, *Colonial Urban Development*, pp97-122.
[83]The development of racism as an ideology in British India has been described as a process where, "the ideas forged in the crucible of 1857 were hammered into shape on the anvil of racial and political theory", in T.Metcalf, *The Aftermath of Revolt*, p310.

The Criminal Lunatics.

A small but significant group of those admitted to the asylums has yet to be mentioned though. The number of criminal lunatics in the asylums is often difficult to calculate as the information available is patchy. For example the earliest details available for the Dullunda asylum are for 1856 and 1857. The report mentions that in 1856 there were 36 male and 3 female prisoners in the asylum and 8 male life convicts. In 1857 there were 35 male and 2 female prisoners and 8 lifers. What the report fails to make clear is what these are counts of, that is whether these figures represent the total numbers to have passed through the asylum in each twelve month period or whether they were the total numbers remaining on the 31st December of the specific year. Figures are given for the total population of the asylum under each heading elsewhere in the document. So it could be that criminal lunatics represented (47/530) about 9% of the total treated in the asylum in 1856 and (45/514) 8.75% of the total treated in 1857. However if the numbers given were the total remaining at the end of the year then it would be that criminals represented (47/261) about 18% of the population at the close of the year in 1856 and 17.25% at the same time in 1857.[84]

The proportions from the next set of available statistics at Dullunda are definitely for those of totals treated during the year. Thus criminals made up about (33/263) 12.5% of the total number treated in 1862 (the great reduction in numbers treated between 1857 and 1862 is explained in the report as being the result of Government of Bengal Orders of the 27th February 1862 tightening the procedure by which magistrates submitted alleged lunatics and of the increased vigour on the part of the authorities in demanding payment from relatives for the care of members of their families).[85]

The figures from the Dacca asylum are far more detailed for the early 1860s than those of Dullunda. The superintendent himself notes of 1862 that "out of the 296 treated during the year there were fifty-four or 18.29% criminal lunatics, and of them forty-two were confined for the most heinous offences of killing and wounding".[86] From his figures it is also possible to discover that on 31 December 1862 criminal lunatics

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[84]Statements attached to 'Reports on the Asylums for European and Native Insane Patients at Bhowanipore and Dullunda for 1856 and 1857' in *Selections from the Records of the Government of Bengal* no.XXVIII.
[85]*Annual Report of the Insane Asylums in Bengal for the year 1862*, pp7-26.
[86]Ibid., p37.

made up (51/217) 23.5% of the population and that they had formed (11/87) 12.65% of the total admissions in the year.[87]

From 1865 the number of criminal lunatics in each asylum in Bengal was routinely published. Towards the end of the 1860s then in Bengal's four largest institutions it is possible to say that criminals formed up to 20% of the annual admissions, and at the end of the 1860s made up almost a quarter of the population residing in the asylums.[88] Ten years later, in the final years of the 1870s though, it is obvious that criminals have become a more significant group in the Bengal asylums, forming between a quarter and a half of annual admissions and about a third of the total treated in any year. By the end of the 1879 the criminal group constituted a third of the population compared with a quarter ten years earlier.[89]

asylum	% admissions	% total treated	% popn. on 31/12
1867.			
Dullunda	(27/177) 15.25%	(64/394) 16.24%	(50/248) 20.16%
Dacca	(7/77) 9.1%	(53/293) 18.08%	(31/209) 14.83%
Patna	(8/77) 10.4%	(28/193) 14.5%	(24/151) 15.89%
Cuttack	(1/21) 4.8%	(6/49) 12.24%	(5/34) 14.71%
Bengal average.	9.9%	15.27%	16.40%
1868.			
Dullunda	(25/173) 14.45%	(75/444) 16.89%	(58/267) 21.72%
Dacca	(14/99) 14.14%	(45/321) 14.62%	(37/213) 17.37%
Patna	(7/102) 16.66%	(31/255) 12.16%	(27/163) 16.56%
Cuttack	(5/16) 31.25%	(10/51) 19.61%	(9/36) 25%
Bengal average.	19.13%	15.82%	20.16%

[87] *Asylums in Bengal for the year 1862*, pp37-40.
[88] *Asylums in Bengal for the Year 1877*, p41.
[89] *Asylums in Bengal for the Year 1879*, p19.

1869.

Dullunda	(23/184) 12.5%	(81/475) 17.05%	(69/317) 21.77%
Dacca	(22/77) 28.57%	(59/306) 19.28%	(47/210) 22.38%
Patna	(12/99) 12.12%	(39/260) 15%	(26/200) 13%
Cuttack	(6/22) 27.27%	(15/68) 22.06%	(13/35) 37.14%
Bengal average.	20.16%	18.35%	23.57%

asylum	% admissions	% total treated	% popn. 31/12

1877.

Dullunda	(29/81) 35.80%	(96/319) 30.09%	(70/202) 34.65%
Dacca	(24/57) 43.86%	(99/259) 38.22%	(85/206) 41.26%
Patna	(14/81) 17.28%	(65/290) 22.41%	(54/206) 26.21%
Cuttack	(1/14) 7.14%	(14/60) 23.33%	(9/47) 19.15%
Bengal average	26.02%	28.51%	30.32%

1878.

Dullunda	(23/78) 29.49%	(93/280) 33.21%	(75/201) 37.31%
Dacca	(21/42) 50%	(106/247) 42.92%	(82/188) 42.62%
Patna	(15/62) 24.19%	(69/268) 25.75%	(56/199) 28.14%
Cuttack	(9/19) 47.37%	(18/66) 27.27%	(14/48) 29.17%
Bengal average	37.76%	32.28%	34.56%

1879.

Dullunda	(34/134) 23.13%	(108/275) 39.27%	(58/217) 26.73%
Dacca	(27/59) 45.76%	(109/230) 47.39%	(85/198) 42.93%
Patna	(13/97) 13.40%	(68/242) 28.10%	(54/228) 23.68%
Cuttack	(5/20) 25%	(19/68) 27.94%	(18/50) 36%
Bengal average	26.82%	35.73%	32.34%

Table II. Showing Criminal Lunatics as a percentage of total admissions, total treated and total population in Bengal for the years 1867/9 and 1877/9.

This picture from Bengal, of the steady increase over the period of the proportion of asylum patients who were classed as criminal seems applicable in some, though not all, of the other areas of British India although the size of the group rarely equalled that of Bengal. The figures available for the asylum in Oudh[90] shows a steady increase from 1866 onwards of criminal class patients in the asylum and the two mental hospitals in the Central Provinces[91] show dramatic leaps in the proportion of patients admitted, treated and remaining who were criminal class. In other areas though it is a less straightforward task to identify a trend. The Bombay[92] figures for 1869 compared with 1879, if anything, suggest a drop in the percentage of those being admitted over the twelve month period who were criminal between the end of the 1860s and the end of the 1870s, and even when the totals for the last three years of each decade are averaged out it seems that at most the percentage has remained constant. The proportion of those remaining at the end of the year who were criminal shows only a slight increase from the last three years of the 1860s to those of the 1870s as well. This is similar to the situation in Madras.[93]

Perhaps the most significant set of figures though is those which show the proportion of the population incarcerated by the British in this period as criminals who were confined in the asylums as opposed to the lock-ups and prisons. Only in Bengal and the Central Provinces was more than 1% of the total incarcerated population resident in an asylum at the end of a year by the end of the 1870s and while figures available for the other provinces suggest in most cases a rise in the proportion of those confined being so in an asylum over the period (Bombay being a notable exception) the figures remain extremely small.[94] The issue arises then of the distinctive characteristics of this small group that so necessitated separate provision.

It has been suggested in studies made of the treatment of the criminal lunatic in England that, during this period, "something of a stereotype of the criminal lunatic as a

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[90]Statements attached to *Report on Dispensaries and Lunatic Asylums in the Province of Oudh for the Year 1875.*

[91]*Report on the Lunatic Asylums in the Central Provinces for the Year 1876*, pp10-19; *Report on the Lunatic Asylums in the Central Provinces for the Year 1880*, pp12-14.

[92]*Annual Administration and Progress Report on the Lunatic Asylums in the Bombay Presidency for the Year 1879*, pp8-10.

[93]Statements attached to *Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1879-80.*

[94]*Annual Report on the Jails of Bengal for the Year 1879*, pxiii; *Report on the Jails of the Central Provinces for the Year 1879*, p4; *Report on the Condition and Management of Jails in the Province of Oudh for the Year 1875*, p2; *Report on the Administration of the Jails of the Madras Presidency for the Year 1879*, p51; *Report on the Jails of the Punjab for the Year 1879*, p4; *Annual Report of the Bombay Jails for the Calendar Year 1879*, pp4-13.

violent dangerous lunatic was elaborated" which was "further enhanced by the legal fraternity's obsession with establishing links between insanity and violent crime".[95] The popular market for psychiatric literary productions and the memoirs of ex-prisoners all helped to embellish this image of the violent criminal madman in the lay imagination. It could be then that this stereotype, firmly established in the culture of the British who acted as magistrates in India, was transported with them and took root in the criminal justice system they operated.

When the crimes for which the criminals in asylums are being detained are listed this thesis could find support. It appears that passage into the asylum is helped if the crime was against the person. Such figures were only made available intermittently and the most complete figures are available for Bombay at the end of the 1870s where such crimes (murder, grievous hurt, assaults, homicide, rape, suicide etc.) account for between two thirds and three quarters of those criminal lunatics treated in the four largest Bombay Presidency asylums in any one year. Murder is always the largest category of crime for which criminals are detained in the mental hospitals.

The problem with this explanation for criminal admissions to the Indian lunatic asylums is the very small number of those violent criminals actually to end up in an institution for insanes. It is difficult to track down the totals of those incarcerated in prisons at any one point for any one crime and have comparable statistics for the asylum. It is possible to note such figures though like that in the Bombay Presidency when there were 315 convictions for the violent crime of 'grievous hurt' in 1880 alone,[96] and yet there was a grand total of 18 criminals resident in asylums associated with this crime (note this is total resident not total admissions for the year, it is impossible to know how many of this number were admitted in 1880). There must be something distinctive about these 18 cases to distinguish them from the many others admitted to prison while they were being committed to the asylum, most 'grievous hurt' is violent so the issue of whether these were simply the 18 most violent criminals or whether there were other factors which influenced the decision to admit these inmates to an asylum must be addressed.

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[95]J.Saunders, 'Magistrates and Madmen: Segregating the Criminally Insane in late nineteenth-century Warwickshire' in V.Bailey (ed.) *Policing and Punishment in Nineteenth-Century Britain* (Croom Helm London 1981), pp221-2.

[96]*Report on the administration of Criminal Justice in the Presidency of Bombay for the year 1879*, p31.

Work done on the processes involving criminal lunatics in Victorian Britain emphasise the importance of local factors and decisions which ultimately served to decide whether an individual found his/her way into an asylum. Using this focus in the Indian study it will be argued that the admission of criminals to the lunatic asylum can be understood as moments in local administrative machinery or the working out of institutional management strategies rather than meta-narratives of colonial anxiety.

Witnesses.

The importance of witnesses at some stage in legal proceedings is focused on in British case studies. Nigel Walker includes in the two volume study *Crime and Insanity in England* the observation that, "until the 1860s when prison doctors were at last required to inspect every prisoner regularly the recognition of disorder depended largely on fortuitous circumstances". On such set of circumstances was that, "the prisoner might have relatives who could draw attention to his mental state".[97] Joel Peter Eigen, in his recent study, stresses the importance of witness testimony in early nineteenth century trials where insanity was an issue and emphasises the weight given to it in comparison to that given by so-called expert medical witnesses.

> It is clear that neighbours, lovers and relatives of allegedly mad prisoners were appearing in court under much the same rubric as acquaintances of any prisoner whose past behaviour might be thought to have a bearing on the jury's deliberation- that is, as character witnesses. After all, acquaintances of sane prisoners appeared not as 'experts' in human character but as intimates of the accused, informing the court of the prisoner's habitual functioning.[98]

Despite the variety of this testimony, from a simple reference to neighbourhood knowledge to intimate accounts of life with the prisoner, it seems that the courts were prepared to take full account of such observations. Eigen concludes that "whether it was a surfeit of folk wisdom that attended the experience of madness or a belief that it was not particularly mysterious but decipherable by the 'inexperienced' eye, mad-doctors in court faced special obstacles. The observations of lay witnesses were apparently given the aura of officially sanctioned opinion".[99]

Circumstances in India were certainly such that the presence of those willing to point out that a prisoner had mental health problems could be decisive. Most doctors in

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[97]N.Walker and S.McCabe, *Crime and Insanity in England: New Solutions and New Problems,* Volume II, (Edinburgh University Press 1973), p50.
[98]Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-doctors in the English Court*, (Yale University Press 1995), p106.
[99]Ibid., p121.

charge of jails and lock ups would have had little or no expertise or training in the diagnosis of mental illness and indeed those given charge of a prison often had so many other duties in a station that even if he had it would have been unlikely that he would have spent sufficient time in contact with the inmates to notice those with symptoms.

Indeed the difficulties of cross-cultural diagnosis would have increased the importance of the witness in Indian cases. The problems involved in determining 'insanity' in legal proceedings in the colonial environment has been discussed elsewhere and would certainly have featured in India in this period.[100] Where a judge or doctor might have missed behaviour in an inmate that might have been deemed so inappropriate within his/her own culture and community that he/she would have been seen as insane by that community a representative presenting him/herself as a witness to that insanity would have alerted the legal authorities to the possibility of madness complicating the case.

A series of examples from the records of the North-Western Provinces in the early 1860s offer a glimpse of a system where the intervention of lay witnesses in the medico-legal process of establishing responsibility for a crime appears to be the decisive element determining the verdict.

For example, there is the case of Koonj Beharee Singh,[101] accused of culpable homicide. On 25 March 1860 he was eating at the house of a local zamindar when the victim, Dulgunjun, a Gorait, approached despite being forbidden by the defendant to do so whereupon the Gorait was clubbed on the head by the defendant. Dulgunjun's response was to announce his intention of reporting his assailant to the thannadar and to start out on this course, as a result of which he was chased and dealt a fatal blow by the defendant with the same club.

In disposing of the case the Sessions Judge, one A.Swinton, decided that Koonj Beharee Singh's decision to attack the victim for a second time when faced with the prospect of being reported was a rational one and sufficient evidence of his sanity to hold him responsible for his action. He was sentenced to two years imprisonment and a fine of Rs.50.

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[100]"The labelling of the mad African as carried out in the colonial court room then, was often a confused and hesitant business", M.Vaughan, *Curing their Ills*, p107.

[101]NWP Judicial (Criminal) Proceedings July 1861, 89-91A: the account of this case is taken from the Session Judges correspondence with the Government of the North-Western Provinces, 89-90A.

However the Sudder Court acquitted him "by reason of unsoundness of mind not wilfully caused by himself, he was unconscious and incapable of knowing at the time of committing the culpable homicide with which he is charged that he was doing an act forbidden by law". The medical evidence for such a verdict is less than unequivocal. The Officiating Civil Surgeon deposed that

> I examined Koonj Beharee Singh on the 15th June and he was then in an unsound state of mind he had been under treatment for some weeks, during which time a considerable improvement had taken place. As there were very few signs of insanity, I think the aberration must have been of recent date. He did not show any violent symptoms, and gave incoherent replies to questions, and was occasionally restless, his acts betrayed symptoms of weakness of intellect. I do not consider he has completely recovered and it would be inadvisable at present to set him at liberty. I would recommend that he be forwarded to the Insane Hospital.

Elsewhere in the papers the Sessions Judge noted that "Dowlut Ram, native doctor, deposed that defendant was insane when admitted into the hospital on 5th May 1860 and continued in that state 'til the end of August and did not recover his senses before the 1st September". These testimonies hardly assert that the defendant was insane at the time the crime was committed. The statements of lay witnesses though give every reason to suggest that he could have been. Although only available in summary form, the flavour of the testimony is preserved. Goolzar Chumar, son of the victim, stated that the defendant seemed intoxicated. Another witness according to Swinton's summary deposed "that defendant was seen smoking ganja at the time of the occurrence and was not in his proper senses". Significantly, Mungra Koeree and Goopta Doobey "depose to the fact of defendant being subject to fits of insanity for several years: they live in his village".

While the medical staff involved state that on their seeing him (in both cases a number of weeks after the incident) he was insane, this falls far short of establishing that he was insane at the moment of the criminal act. What the lay witness testimony does is provide the grounds for backdating the official medical diagnosis to the time of the event, the suggestion that he was smoking a drug widely believed by the British to be linked with insane behaviour and indeed the idea that he was prone to insane episodes justifying the extension of the medical officers' observations on his mental state back to the day of the crime. This in turn justified the acquittal on the grounds of insane at the time of the act.

An even clearer example of the central place of witness testimony in Indian criminal trials which feature insanity is the case of Kishore,[102] charged with the murder of his wife but acquitted on the ground of insanity. Consider the deposition of the medical officer involved in the case.[103]

> Q.What is your name and profession?
> A.William R.Rice, Civil Assistant Surgeon.
>
> Q.Have you examined the prisoner Kishore, and if so, please state the result of your observations as to his state of mind?
> A.When he first entered he appeared to be labouring under a little excitement which subsided in a day or two since that time he has shewn no signs of insanity. I consider his moral faculties to be inferior to the general order of men of the same class. That he is a man of excitable temper.
>
> Q.Having heard the statements of the prisoners' relations as to his previous state of mind, and the insanity of his father, are you of opinion that he was labouring under a temporary fit of insanity at the time he committed this crime?
> A.Yes. I am of opinion from the evidence I have heard given, that he was labouring under an irresistible impulse to destroy life in fact he was labouring under homicidal mania.

The impression which this exchange gives is of a medical officer who had noticed strange behaviour in a patient but who hesitated to call it insanity until the intervention of lay witnesses to positively identify the behaviour as such. Elsewhere in the papers R.B.Morgan, a judge, noted the following:

> The medical officer, although he pronounced him sane at the time his [Kishore's] deposition was recorded, stated that when he first examined the prisoner, he appeared to be labouring under a little excitement which subsided in a day or two, and having heard the statements of the prisoners' relations as to his previous state of mind, the Civil Surgeon was of opinion that the prisoner was labouring under an irresistible impulse to destroy life. It appears to me therefore that there is evidence sufficient on the record to enable us to pronounce that the prisoner was insane. That he was incapable of discriminating at the time that he was committing a criminal act.[104]

It was thought then that when Kishore gave his deposition the medical officer believed him sane and only came to positively identify him as insane as a result of the witness testimony. Moreover, for the legal authorities this was perfectly ample by way of proof that the accused was insane at the moment of the act.

The witness testimony is only available in the summary of the Sessions Judge at Saugor, R.Drummond. Kishore's sister asserted that their father had been insane for twelve years prior to his death, and his elder brother that on one occasion Kishore had

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[102]NWP Judicial (Criminal) Proceedings February 1861, 82-84A.
[103]Deposition on Oath of the Civil Surgeon Saugar 13 December 1860, 83A.
[104]R.B.Morgan's Opinion 8 January 1861, 83A.

jumped into a river from which he had needed to be rescued. He had also beaten his wife a fortnight before the murder and as a result of this she had taken him to a 'mad Doctor' at Mowa Khera where she had left him for six days. His mother agreed that her husband had been insane and that her son "was also not in right mind". A neighbour who had undertaken to grow melons in partnership with Kishore recounted how he had ceased to work and "behaved in an insane manner".

There are obviously considerable problems with evidence of this kind. The process of gathering such information, translating and recording it is obscure, and an awareness of the legal, medical and colonial discursive practices in which the record of the Indian voices was formed must necessarily colour any treatment of the witness statements.[105] The agendas of the witnesses involved must also be taken into account. But what is clear is that the intervention of Indian lay witnesses was decisive in having Kishore classified by the British medical and legal authorities as insane at the time of his committing a criminal act. The medical officer is only moved to assert insanity when neighbours and relatives arrive to attest to it.

The importance of witness intervention is also evident in the case of Kulloo.[106] He was heard to say that he must "avert the black day by burning the thatched houses"[107] and set out to fire the huts immediately adjacent to his own. Upon being taken into custody he was sent to the Civil Assistant Surgeon of Baitool, one Henry King. He notes in a letter to the Joint Magistrate when returning him to the Jail that

> with reference to a person named Kulloo, supposed to be a lunatic and under observation in the Jail Hospital for some days, I have the honor to inform you that his conduct has not been such as to justify my certifying his insanity or irresponsibility for his action.[108]

Even when Kulloo is sent back to him after attempting to set fire to other prisoners King maintains that he is "unwilling to certify positively that he is so far irresponsible for his actions as to be an unfit object for punishment".[109] In a deposition for the case King asserts that "his manner has been eccentric but not positively insane".[110]

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[105]For a consideration of the difficulties in using colonial legal records see for example R.Guha, 'Chandra's Death' in R.Guha, *Subaltern Studies II* (Oxford University Press 1983) or S.Amin, 'Approver's Testimony, Judicial Discourse: the case of Chauri Chaura' in R.Guha, *Subaltern Studies V* (Oxford University Press 1987).
[106]NWP Judicial (Criminal) January 1861, 32-34A.
[107]Abstract of the Examination and Grounds and Date of Commitment for Trial 23 March 1860, 34A.
[108]Civ.Asst.Surg. to Mag.Baitool 11 January 1860, 37A.
[109]Civ.Asst.Surg. to Mag.Baitool 10 February 1860, 39A.
[110]Deposition of Henry King 16 March 1860, 40A.

Despite these refusals of the medical officer to positively classify Kulloo as insane he is acquitted on the ground of insanity at the time of the commission of the act. Such a verdict evidently surprised many at the time, as the Government of the North-Western Provinces contacted the Sessions Judge who oversaw the case stating that "it appears ... desirable to the Lieutenant-Governor that the Government should be placed in possession of the evidence taken in proof of insanity".[111]

This evidence comes in the form of a *Translation of evidence in the above case regarding the insanity of defendant as called for in the letter of the Sessions Judge (no.626) Dated 8th November 1860.*[112] In this are reproduced, in English, the following witness statements:

> Ragho, lohar- Defendant constantly roves about like a lunatic, and does not work for his livelihood. About 20 days since, defendant attempted to set fire to Sewa's house, about 8pm; I and Ramsuhaie caught him in the act. A little of the house was burnt. I don't know whether defendant is given to intoxicating drugs.
>
> Dewar- Defendant's conduct is like a lunatic's; he sets people's houses on fire, and beats his household. Ramsahoie's and Bodee's houses were fired by him. I have seen him carrying about torches.
>
> Ramsuhaie- Defendant roves about like a lunatic, but I imagine him to be only of a sulky and morose temperament not really mad. He set fire to Serva and Bugora's houses and also to Gunga Deen's house in Baitool; I and Raghoo saw him light Sewa's house with a torch. He has fired several people's houses.
>
> Juddonath Suhaie, Jail Darogah- Submits an urzee on 2nd February 1860 that Hoosein Mohamed, prisoner, had reported that defendant had taken the 'chiraj' from Barrack no.3 and burnt him and keeps pulling his clothes and won't allow him to sleep.
>
> Hoosein Mohamed- States that defendant makes a row at night, and tearing his clothes, dips them in oil and attempts to burn me. He burns other prisoners and won't allow anyone to sleep.

That the first three witnesses know that he roves about and does no work suggest that they are neighbours, as these opinions point to prolonged observation of his habits. The weight of opinion amongst his neighbours is that he has very much acted in an insane manner. If such evidence were not enough then Kulloo's behaviour has been sufficiently disruptive to bring him to the notice of the jail authorities. Details of this behaviour are included alongside the opinion of his neighbours in order to corroborate that opinion that he has been acting insanely. These witness statements coupled with disruptive behaviour in an institution are sufficient to have him labelled insane, and

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[111]Gvt.NWP to Sessions Judge Saugar and Nerbudda 3 November 1860, 35A.
[112]Translation of Evidence 8 November 1860, 40A.

acquitted on the assumption that his insanity is sufficiently longstanding to have included the period when the attempted arson of which he was accused took place. Indeed the significance of this case is that *despite* the judgement of the British medical officer the defendant is judged insane on the testimony of his neighbours. The presence of Indian witnesses in this case is not just decisive, it is the sole factor in the positive classification of Kulloo as insane at the time of the crime.

It is an administrative anomaly that has preserved these details as no other administration within British India chose to enter such cases in the A proceedings during this period and the North Western Provinces only recorded cases where there was some difficulty, such as a procedural irregularity. Even then they soon discontinued this practice, preferring the system followed elsewhere of including only brief summaries of such cases in the B proceedings indexes and failing to reproduce all the papers referring to these cases in the annual volumes. So for example, the full set of papers relating to Sheobaluk Singh,[113] appear in the A Proceedings in 1864, as his is a case where there appears to be irregularity in the legal process. As the Secretary to the Government of the North-Western Provinces points out in a letter to the Magistrate of Goruckpore which is reproduced in full, "as it appears that the man was insane at the time of his trial he could not have been in a position to make his defence; and it was quite illegal to proceed with the trial. The proper procedure is pointed out in Sections 388 to 390 of the Code, and has been explained further in a Circular of the Sudder Nizamut Adawlut, no.9 dated 14th April 1863. The trial, I am to point out, should have been postponed until the man was capable of making his defence".[114]

However by 1865 a similar case, that of Ramdhun, only appears as the following summary in the B Proceedings index in 1865:

> The Magistrate of Goruckpore having solicited orders as to the disposal of one Ramdhun alias Fukeer Koeree was confined in the Jail of that District as a criminal lunatic, on a charge of wounding his wife, but who was, subsequently, reported to be sane was directed to send the prisoner to the Benares Lunatic Asylum to be there treated under Section 395 of Act XXV of 1861.
>
> Mr. Ouseley was requested, however to explain the irregularity of which he had been guilty in not at once staying proceedings as soon as he became convinced of the prisoner's insanity in consonance with the provisions of Chapter 27 of the Criminal Procedure Code instead of passing an illegal order of acquittal.

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[113]NWP Judicial (Criminal) June 1864, 29-35A.
[114]Gvt.NWP to Mag.Goruck 24 June 1864, 34A.

> He explained that the case was disposed of by the Joint Magistrate Mr. E.S. Robertson without reference to him and without his knowledge and that the delay of a year which had occurred in submitting a report was due, perhaps, to the transfer of that officer from Goruckpore to another station shortly after the trial.[115]

As a B Proceeding, the full set of correspondence is not reproduced and so the only clues to the circumstances of Randhun's case are those in the above summary. So, with only a few examples of cases with full sets of papers available, it is difficult to establish the statistical occurrence of cases of criminals being declared insane at the time of the crime due to the intervention of lay witnesses as opposed to the testimony of for example a European medical officer.

Even if it were possible to establish such a figure its meaning would be obscure because of the difficulties in finding examples where the failure of a lay witness to intervene has resulted in someone who is mentally disturbed, and who was so at the time of the commission of the crime, passing through the criminal justice system and being sentenced as responsible for the act. This would involve trying to diagnose from legal records symptoms of insanity in defendants who were not perceived to be mad at the time.

There is however, the odd tantalising suggestion that this was the case, or at least medical personnel at the time believed they had found an example. Gokhall[116] was admitted to the Lucknow asylum from jail. Consider the opening statement of his case record:

> A prisoner- had been violent and struck someone was sentenced to 6 months imprisonment- it then appeared he was insane- no history of his case is obtainable.

If he is classified as 'a prisoner' upon reaching the asylum this implies that he is still under sentence. In other words his insanity did not become clear at a point where it allowed him to be acquitted, indeed it is likely then that he was already in prison serving his sentence when his symptoms were noticed. 'No history of his case is obtainable' is a stock phrase in the case notes implying that it has been impossible to study the aetiology of his disorder as there were no relatives/friends available to answer questions as to his previous behaviour. The choice of 'it then appeared he was insane' is significant as it implies that the medical officer believes his condition to be of longstanding, he did not become insane in jail, it was only there that it was noticed,

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[115]NWP Judicial (Criminal) 24 June 1865, 22B.
[116]Case Book IA, patient no.10, admitted 14 March 1860.

especially as elsewhere in the case notes there are entries which show that the superintendent was able to clearly state when he thought insanity was a product of the prison, as opposed to predating it. Such is the case of Sooraj Bullee of whom it was said: "This man was a life prisoner in the jail of Lucknow. It appears that during his imprisonment he became insane".[117]

With no witnesses available to explain his sudden violent attack, Gokhall is churned through the criminal justice system as a relatively unimportant assault case (he is classed as an 'aheer' and a 'labourer' in the case notes so he is evidently of little importance to the British as he is low income and low status) and given a six month sentence. It is only once in prison and under the regular scrutiny of a European medical officer that his behaviour is noticed and an 'insanity' diagnosis attached to him. Of course there are other ways of interpreting this evidence and the very unimportance of such a figure precludes his appearance elsewhere in the colonial records so further corroboration of his case is unlikely, but nevertheless it can be tempting to take this brief description as evidence of the importance of lay witnesses in the fate of a disordered criminal. In the examples above the lay witness was decisive in the legal process ending in a verdict of insane at the time of the act. There is certainly the suggestion in this last example of Gokhall, that the lack of lay witnesses to draw the attention of the British authorities to his state of mind has resulted in a disturbed offender being processed as perfectly sane and culpable.

Jail transfers.

This final example of Gokhall points to another category of prisoner who ends up labelled a 'criminal lunatic', the prisoner who was considered sane enough to stand trial, was convicted of the crime with which he/she was charged and was sentenced to a term in jail but who ends up transferred from that jail to a lunatic asylum as insane. A similar category existed in Britain and has been the subject of a number of studies.

Janet Saunders concludes, for example, that while "prisons were designed to cope with some amount of difficult or unruly behaviour, and the Warwick case notes show that aberrant behaviour and other symptoms of possible mental breakdown might be dealt with for weeks by the prison medical officer before certification was turned to as a last resort ... it was violent expression of mental 'disorder' that was most likely to

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[117]Case Book IA, patient no.156, admitted 14 December 1861.

lead to the certification of a prisoner".[118] Walker and McCabe point out that "the transformation of prisoners into patients has never done more than relieve the gaols of the obviously disordered",[119] and that often the classification of a prisoner as 'lunatic' and his transfer had to be the result of circumstances where "his behaviour might be sufficiently violent or bizarre to impress even the ignorant prison staff".[120]

Violent behaviour was disruptive of jail discipline and as such prison managers sought to relieve themselves of those who refused to submit to jail discipline by sending them off to the asylum. Watson points out in an important study that it was not just the spectacularly disordered who were branded insane and transferred from jail to asylum. He emphasises that "there was a growing awareness of a category of mental abnormality that caused problems of management",[121] a category labelled as 'the weak-minded'. Penal discipline in this period operated through a system of rewards and punishments, and the weak-minded individual was deemed to be he/she who was unable to differentiate between the two, as Watson says, "it is clear from contemporary sources that the original meaning of weakminded (as used in the prison) was literally 'unfit for discipline' on grounds of mental incapacity".[122] The prisoner who failed to react differently to punishment or reward, and indeed often failed to react at all to either was unsuited to the modern prison system.

What the weakminded prisoner had in common with the violently disruptive was the fact that he/she was a complication in the management strategies of the prison. The prison therefore sought to be rid of such complications by attaching the label 'insane' to those who behaved in such ways, thereby justifying their removal from the system.

The inmates transferred from prison to the asylum as 'insane' in the Indian system similarly seem to fit into either the violent or the weakminded category, and it is easy to understand why such prisoners could and would be removed when the peculiarities of the Indian penal system of the 1860s and 1870s are investigated. The behaviour of patients would have to be gauged in terms of compatibility with the priorities of the Indian penal system. By the end of the 1860s these priorities were financial, as the Inspector General of Jails in Bengal boldly declared: "The basis of the existing system

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[118]Janet Saunders, 'Magistrates and Madmen', pp225-6.
[119]N.Walker and S.McCabe, *Crime and Insanity in England* (Volume II), p38.
[120]Ibid., p50.
[121]S.Watson, 'Malingerers, the 'weak-minded' criminal and the 'moral imbecile': how the English prison medical officer became an expert in mental deficiency, 1880-1930', in, M.Clark and C.Crawford (eds.), *Legal Medicine in History* (Cambridge University Press 1994), p234.
[122]Ibid., p226.

of prison discipline in Bengal is remunerative industry as the best instrument of punishment and reform".[123] He went on to make it clear that

> I am of opinion that remunerative industry is the basis of all real reformation of prisoners in a country where religious instruction is prohibited; that prisons ought to be and can be made self-supporting institutions and that from the introduction of a proper system the ultimate repayment to the state of the whole of the great cost now incurred for the maintenance of prisons in India may be expected.[124]

By 1867 Alipore Jail, the most developed of Mouat's prison/factories was making a net profit of Rs.250 000 and was able to afford to import jute-spinning machinery from Britain. Not that Bengal was the only administration to prioritise financial aspects of the penal system, in the Punjab, for example, the industrial system in the prisons was able to produce carpets of sufficient quality by the end of the 1860s to find a market in England.[125]

Such priorities, and the development of sophisticated systems for using convict labour in profitable pursuits had a number of critics and was the cause of concern for some involved in penal management. Arthur Howell noted in 1868 that

> it would seem that in all Presidencies, and especially in Bengal, the remunerative theory of prison labor prevails to an extent which makes it very doubtful whether the primary object of the sentence -punishment- is steadily and systematically kept before the prisoner.[126]

Sir George Couper, who was the head of the Oudh Jail Department and who claimed to have visited nearly every jail in the North-Western Provinces while Under Secretary to that Government worried that while the object of labour in jails ought to be to "inspire the person who has to perform it with the feeling that if he can once get over the period of imprisonment he will take care not to incur the punishment again", in India this was far from the case. The chief cause for this was, in his analysis, "the desire to make jail labour remunerative, that is, to make the jails as far as possible, self-supporting".[127]

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[123]Note on Jails and Jail Discipline in India 1867-68 by Arthur Howell in Home (Judicial) 9 January 1869, 39-52A.
[124]Ibid.
[125]This summary relies on details from the annual reports of the prisons mentioned summarised in Arthur Howell's Note.
[126]Ibid.
[127]Memorandum by Sir George Couper in Home (Judicial) 9 January 1869, 39-52A

Nevertheless the fact that such concerns were still being voiced throughout the 1870s[128] serves to emphasise the continued prioritization of financial goals in the Indian penal system. Where prisoners were likely to be difficult to fit into the systems of organised labour which prevailed in Indian jails some method of disposing of them was sought.

> As recommended by the Inspector-General of Prisons North Western Provinces, His Honor was pleased to sanction the release from the Lullutpore Jail of the prisoner Sooksah, who had been sentenced to two years' imprisonment for harbouring a dacoit on the grounds of mental imbecility, blindness and inability to undergo labor.[129]

This course of action appears to have been unusual, and far more common was an entry in the Proceedings like the following:

> At the instance of the Inspector-General of Prisons North Western Provinces, His Honor was pleased to sanction the transfer to the Benares Lunatic Asylum of Gunput Chumar, a prisoner in the Benares Central Prison who was certified to have become insane.[130]

Where individuals seemed unable to comprehend simple instructions or concentrate long enough to achieve a task, or where they physically resisted being put to a task or were liable to an unpredictable outburst which would disrupt not only their work but that of others around them, they were likely to be tolerated for only so long. The most common route out of the prison for such prisoners was into the asylum.

A crucial component of the industrial system in Indian prisons was the granting of commission on the profits gained to the Indian staff of jails. In 1875, when the wisdom of such a system was being questioned,[131] it emerged that all of the administrations in India had used the system, although by 1875 it had fallen out of favour in Bengal, Madras and Assam. The commission granted varied from 5% in Burma to 20% in Mysore and Coorg and was usually granted to the head of the Indian staff as an incentive for them to organise prisoners in remunerative occupations and to ensure that the inmates worked: "As Jailors know that the amount of commission which they can earn depends on their individual exertion in the manufacture and actual sale of goods, they are interested in obtaining a good out turn of work".[132] Indeed, an

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[128]"Punitive labour -one of the essential conditions of prison administration- appears often to have been made subsidiary to the introduction of remunerative forms of industry", from Gvt.Bengal to GOI in Home (Judicial) August 1875, 27-47A.
[129]NWP Judicial (Criminal) 20 February 1864, 15-17B.
[130]NWP Judicial (Criminal) 23 September 1865, 26B.
[131]Home (Judicial) August 1875, 27-47A.
[132]Gvt.C.Provs. to GOI 6 April 1875 in Ibid.

interesting variation on this system came to light in the response of the Inspector-General of Prisons in the North-Western Provinces:

> I may remark at once that there is an essential difference between our practice and that which held in Bengal. In both cases 10% on net profits were allowed to be distributed, but while in Bengal the Jailor or Darogah got the whole of this commission, in these Provinces he receives only a percentage of its amount, the rest being divided up by the subjoined scale amongst other officials named.[133]

The list of 'officials named' included assistant jailors, warders, Darogahs and 'deserving prisoners'. This would mean that there were staff (and apparently in the NWP some inmates) in the jails in whose interest it was to ensure the smooth-running of the convict work, and in whose interest it would have been to notice individuals whose behaviour made them disruptive of profit-making activities and to have them removed if they proved intractable.

Indeed, in addition to this layer of surveillance, a curious feature of the Indian penal system as it developed in the 1860s meant that the disruptive prisoner in certain District or Central Jails would have been routinely under the jurisdiction of the local superintendent of the lunatic asylum. Pioneered in the North-Western Provinces in 1862, where it was decided that

> Civil Surgeons, who generally remain many years at the same stations, have a great deal of spare time on their hands, and having to visit the Jail every day professionally, are obviously the right men to have charge of the prisoners and all matters connected with them,[134]

the system of putting the Civil Surgeon in charge of the local District or Central Jail became standard procedure throughout British India (except in Madras) during the 1860s. There was a change of attitude towards this system at the end of the decade and it was decided at the Government of India level that "the existing orders might be so far modified that where non-medical men, who are well suited to the responsible charge of a Central Prison, are available, they should be preferentially employed",[135] but in practice medical officers continued to be appointed to the charge of even the largest prisons throughout the 1870s. For example, in the Judicial Proceedings of the North-Western Provinces was the following entry:

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[133]IGP.NWP to Gvt.NWP 22 March 1875 in Home (Judicial) August 1875, 27-47A.
[134]IGP.NWP. to Gvt.NWP 11 December 1861 in Home (Judicial) 19 May 1862, 18-19A.
[135]Resolution in Home (Judicial) 19 June 1869, 53-56A.

> Notification published granting Dr. Whishaw two month's privilege leave and appointing Dr. A.Cameron, Civil Surgeon Bara Banki, to officiate as Superintendent Central prison and District Jail Lucknow, during Dr. Whishaw's absence.[136]

The Civil Surgeon at a major station like Lucknow would also have been the superintendent of the local lunatic asylum, and as he was expected to visit both the prisons and the asylum in his charge daily, bizarre and disruptive behaviour in prison inmates would have as a matter of course been a subject of the scrutiny of the local mental health official.

The case note for Rajoosoa contains a number of these elements.

> Oct 1861. This man was tried for murder of his wife and sentenced to perpetual imprisonment. Shortly after when in Jail he showed marked symptoms of mental aberration, scarcely spoke, would not work. Continually whined, was restless + apparently uneasy but had no definite complaint- seldom appeared to sleep. I had him removed to Lunatic Asylum. He was always quiet, never turbulent, but could not be persuaded to do any work. Sometimes tried but had no jee for anything. Appetite poor- continually begged in a piteous tone to be released- his general health was never good.
>
> Sept. 1862. This man has been generally quiet and perfectly harmless- has for some time suffered from diarrhoea, looks anaemic + is falling off rapidly.
>
> Octr. He continued to decline + refused food- died 29th Oct. 1862.[137]

While never spectacularly disruptive, Rajoosoa's melancholic state of mind had ensured a passive resistance to any attempt to get him to work in the Jail. This had been observed by the Civil Surgeon while attending to his duties in the prison, and had prompted him to use his authority as superintendent of the prison to order the prisoner's removal to the asylum, where the Civil Surgeon had recorded the details of Rajoosoa's behaviour as he had observed them both in the prison and in the asylum. In this example then it is possible to see the importance of the medical officer's dual role as superintendent of the prison and the asylum and the removal of a patient who, like the examples given by Stephen Watson in his case study of English prisons, was deemed a management problem in penal institutions because of an apparent mental incapacity for the demands of prison discipline.

A shorter entry for Akhroo,[138] is more to the point.

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[136]Oudh (General) 20 September 1872, 402B.
[137]Case Book IA, patient no.141, admitted 14 October 1861.
[138]Case Book IA, patient no.136, admitted 20 September 1861.

1861. Prisoner. Transferred from Lucknow Jail. He had been melancholic and indisposed to work- general health very bad- he suffered from diarrhoea and got gradually weaker and died 2nd Feb. 1862.

Again not violent, but his state of mind made him passively uncooperative when it came to putting him to work, and as such he was a hindrance to the management strategies of Lucknow prison necessitating his transfer.

The following details suggest that Meera Buksh,[139] by virtue of unpredictable and violent behaviour, is an example of an inmate who had been difficult to fit into an organised system of regular prison labour and was subsequently passed on by the jail to the asylum.

1862 Prisoner. Received from Lucknow by warrant and certificate of Civil Assistant Surgeon. On admission was violent and very troublesome. Occasionally in very high spirits and hummed marching tunes (he had formerly been a Bugler in some regiment in the Punjab).

1863 January. For several months there was no improvement in this man's condition. He was dirty + could with difficulty be compelled to wear decent clothing. He was very excitable + abusive- within the last month he has been much more quiet + rational + works regularly in the garden.

Feb. Since last report has steadily improved. Appears now quite rational + conducts himself with propriety. Discharged + returned to Jail Feb. 10/63.

Throughout the period for which case notes are available, there are constantly examples where violence and excitability are central to the case notes of prisoners received from prisons. In the case of Seetul[140] for example, that is all there is:

29 May 1865. A prisoner lunatic, is occasionally violent.

17 March 1871. Died of diarrhoea.

Then there are cases such as Balgobind,[141] whose case note opens with the statement, "prisoner under sect.379 IPC, sent in from the Lucknow District Jail, is suffering from Acute Mania, is occasionally violent", followed by a periodic update to the effect that there is, "no material improvement". Such cases are common even at the end of the period contained in the surviving case books.

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[139]Case Book IA, patient no.218, admitted 6 August 1862.
[140]Case Book II, patient no.184, admitted 29 May 1865.
[141]Case Book IV, patient no.216, admitted 20 August 1870.

The case note of Mosst.Kudro[142] provides an interesting insight. Carrying with her a diagnosis of 'hysterical mania' the following are the opening details of the account given of her in the files.

> 7th August 1869. Prisoner under Sect.363 IPC. Not violent. This woman is a prisoner lunatic, sent in by the Supt.Central Jail Lucknow, is given to very lewd and immoral acts.

This would seem to suggest that it was not just violence or 'weak intellect' that obstructed the smooth-running of penal institutions. If this is an example of a prisoner transferred because she caused disruption to the management of the prison, it is an example of overt female sexual behaviour proving unmanageable in a Central Jail where contact with males would have been unavoidable, be they staff or prisoners.

The case notes then contain ample evidence to suggest that the observations made in English prisons, of prisoners being classified as insane for behaviour which was disruptive to penal discipline in order to justify their transfer out of that system, can similarly be made in the Indian system during this period. Indeed it is more readily understandable in a system such as that which prevailed in the jails of the 1860s in British India, where the demands of, and structures associated with, trying to generate marketable products through convict labour would have militated against tolerance of disruptive behaviour in the jail and in certain cases would have facilitated the transfer of patients through the occupancy of prison and asylum superintendent positions by the same medical officer.

In dealing with the factors behind the admission of those classified as criminal lunatics into the asylum from jail, this account has focused on the working of certain systems, the legal and the penal, and pointed out the localised strategies and influences which resulted in certain inmates ending up in asylums. The question of what it was that differentiated that 1% or less of the incarcerated population which ended up in the asylum from the vast majority which remained in prisons is answered not by reference to meta-narratives of colonial anxiety but by looking to the strategies of local administrators for coping with the demands and difficulties of the systems they were required to operate.

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[142]Case Book IV, patient no.101, admitted 17 August 1869.

There is though one interesting set of case notes which suggest that meta-narratives did have, in certain cases, a considerable influence on the composition of the 'criminal lunatic' population in asylums. The female proportion of the criminal lunatic population in British India as a whole was extremely small, reflecting the small proportion of the total incarcerated criminal population in the prisons of India that was made up by females,[143] so that females made up from about 15% of the asylum criminal population in the Central Provinces to about 3% in the Punjab at the end of the 1870s. Of the 18 case notes in the Lucknow collection which can definitely be identified as female criminal lunatics, it is possible to find 14 on which the crime committed is included. Of these 14, 8 are linked to crimes committed by a mother on her children. Of the others another two can be linked with crimes against children. Both Mosst.Kudro[144] and Mosst.Mooneeya[145] have Section 363 of the Indian Penal Code mentioned on their case notes. This is the punishment section related to Section 361 of the Code which deals with the crime of taking a minor from its lawful guardian.[146]

A typical case note for the women accused of crime against their own children reads as follows.

> Dalooie (f). Mania. 40. Hindoo. Beggar. 16 October/63.
>
> 16th October 1863. Prisoner. Sent in by Deputy Commissioner Roy Bareilly.
>
> 18th November 1865. There is no improvement whatever in this woman's state. She is a criminal lunatic, and was tried and acquitted under Section 394 of the Criminal Procedure Code, of the murder of her two children- with orders to be retained in the asylum during H.M.pleasure vide no. 148 of 15th July 1863 from Govt India to C.C.
>
> 23 August 1866. To be retained in asylum by order of committee.
>
> 26th Decr. 1866. Having been acquitted by the Judicial Commissioner on the grounds of insanity recommended that a commission be appointed under clause 3, Sect. 395.
>
> 8th Jany. 1868. Papers sent with letter 56 of 8th Jany 1868 to Judicial Commr.

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[143]See D.Arnold, 'The Colonial Prison: power, knowledge and penology in nineteenth-century India', in D.Arnold and D.Hardiman (eds.), *Subaltern Studies VIII,* (Oxford University Press 1994), pp166-7.
[144]Case Book IV, patient no.101, admitted 17 August 1869.
[145]Case Book IV, patient no.156, admitted 2 February 1870.
[146]V.V.Raghavan, *Law of Crimes: A single volume commentary on Indian Penal Code 1860 (Act no.45 of 1860),* (Orient Law House New Delhi 1993).

March 10 1868. At a meeting of the Standing Commission under clause 3 Sec.395 of the Criminal Procedure Code no.350 Jan.25th 1868 Oudh Govt.Gazette, Daloo was pronounced sane and fit to be discharged.[147]

The following example is interesting as it suggests that the beginning of 1868 was a clear-out period at the asylum.

Soordiah. Mania. 25. Mussl. Labour. 8 Augt/64.

8th August 1864. Prisoner. Sent in by Deputy Commr. of Fyzabad.

8th April 1865. This woman is a criminal lunatic, and is awaiting her trial for murder of her infant. She occasionally becomes quite sane but relapses to the same state, and is at present much the same as on admission.

23rd August 1866. She remains still insane.

26th Decr.1867. Having been acquitted by Judicial Commr. on grounds of insanity, recommended that a commission be appointed under clause 3 sect.395.

March 10 1868. At a meeting of the Standing Commission under clause 3 Sec.395 no.350 Jan 25 1868 Oudh Govt.Gazette- Soodhia was pronounced sane + fit to be discharged.[148]

Despite their bureaucratic nature, the case notes do occasionally hint at the very real personal tragedies involved. Ramdioh was "said to have become mad from jealousy, her husband having taken up with another woman- in a moment of frenzy she killed her child".[149] Mosst.Doolia was "tried for the murder of her child, was acquitted on the grounds of insanity. Has since tried to commit suicide by hanging herself".[150] Not that all the cases were of murder. The word 'abortion' scribbled in a margin suggests that Phooljaria has attempted to terminate the life of the child she was carrying when examined by the medical officer who wrote her case note. She was a widow at the time.[151] Emamee Khanum had been caught in the act of "selling or trying to sell her child".[152]

The facts that so many of the female criminal lunatics in the Lucknow asylum can definitely be associated with crimes involving children, and the majority of such cases are of crimes of mothers against their own, reflects the influence of British, and indeed

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[147]Case Book II, patient no.11, admitted 21 March 1863.
[148]Case Book II, patient no.124, admitted 8 August 1864.
[149]Case Book II, patient no.93, admitted 16 April 1864.
[150]Case Book IV, patient no.145, admitted 6 December 1869.
[151]Case Book IA, patient no.110, admitted 21 May 1861. Section 312 of the Indian Penal Code dealt with unlawful termination of pregnancies and stipulated that, "A woman who causes herself to miscarry is within the meaning of this section".
[152]Case Book IA, patient no.18, admitted 13 May 1860.

European, cultural understandings of femininity and motherhood in the judicial and penal systems. This is familiar from studies done of infanticide cases in Britain.

Roger Smith, for instance, concludes that "Victorians ... felt that infanticidal women should be objects of mercy",[153] and points to contemporary texts such as *Infanticide: Its Law, Prevalence, Prevention and History* published in 1862 which claimed that, "indeed, it is unhappily true that, from whatever cause it may have arisen, infanticide is not looked upon in the same light as other murders ... There is no crime that meet with so much sympathy, often of the most ill-judged kind".[154] Nigel Walker provides a historical context, suggesting that examples from as early as the seventeenth century show that sympathy for infanticidal women had a long history. For example Lord Chief Justice Hale in 1668 advised a jury how to approach their decision about a mother in a case of child murder: "if they found her under a phrenzy, tho' by reason of her late delivery and want of sleep, they should acquit her".[155] He then shows how the nineteenth century produced similar advice from leading judges, Sir James Fitzjames Stephen (1829-1894) concluding of cases involving murder soon after delivery that "women in that condition do get the strongest symptoms of what amounts almost to temporary madness and ... often hardly know what they are about, and will do things which they have no settled or deliberate intention whatever of doing".[156]

The basis of these attitudes had two elements. The first was the belief that motherhood and femininity were synonymous and that the woman's natural role and inclination was child-bearing and rearing. Roger Smith argues that this perception was so pervasive that although "on the face of it, infanticide was the antithesis of nature: a mother's perverse rejection of her natural function would seem an outrage calling for the strongest possible retribution",[157] so perverse did the rejection seem that it was assumed that only madness could explain it.

The second element was the view that the physical efforts associated with childbirth, indeed all of the physical processes associated with the female's reproductive capabilities, were debilitating and incapacitating. It was assumed that, "beset by a biological life cycle that was deemed fraught with periods of instability- menstruation,

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[153]R.Smith, *Trial by Medicine: insanity and responsibility in Victorian trials*, (Edinburgh University Press 1981), p144.
[154]Ibid.
[155]N.Walker, *Crime and Insanity in England* Volume I, p127.
[156]Ibid., p128.
[157]R.Smith, *Trial by Medicine*, p144.

pregnancy, childbirth, lactation- women were considered to go through periods of insanity which sometimes led to horrifying crimes against themselves, their children or their mates".[158] Indeed, it seems that "doctors agreed that the biological life cycle associated with reproduction caused 'a profound modification of the blood' and hence left women open to periods of intense mental instability".[159]

With such a prejudice so firmly entrenched in British, and indeed European, culture, it is no surprise to see it reappear in the British criminal justice system in India. This is especially so as the place of women in Indian cultures, widely regarded by the colonisers as simply "the degradation of woman by Hinduism",[160] was one of the issues that the British chose to focus their attention on in order to emphasise what they regarded as the morally superior nature of their civilization in comparison to the cultures of those they colonized.

For these reasons, infanticide was a preoccupation of British social policy in parts of British India from the 1830s onwards and legislative approaches emphasised the sympathy for women inherent in the colonial British legal system. Throughout the period of consultation which led to the Female Infanticide Act of 1870 the tone of advice was in favour of "making the head of the family responsible for the practice"[161] and some even wanted to see to it that "the onus of proof of innocence should be on the father, who was to be required to show that the child died a natural death".[162] When the Act[163] took effect sentencing policy is interesting. In Kanpur, for example, "two cases were proved in which the mother and grandmother were sentenced each to 2 years imprisonment, the father of the child to 5 years and two accomplices to 3 years".[164] The high incidence of infanticidal women in British asylums in India reflects the sympathy felt by the male operators of the legal and penal system which was a product of patriarchal cultural meta-narratives which had produced specific

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[158]R.Harris, *Murders and Madness: medicine, law and society in the fin de siècle*, (Clarendon Press Oxford 1989), p35.
[159]Ibid.
[160]J.Wilson, *History of the Suppression of Infanticide in Western India under the Government of Bombay*, (Smith and Taylor Bombay 1855), p430.
[161]L.Panigrahi, *British Social Policy and Female Infanticide in India*, (Munshiram Manoharlal New Delhi 1972), p121.
[162]Ibid., p123.
[163]It is interesting to note that when the Act was finally passed in 1870 the law member of the Government of India was Sir James Fitzjames Stephen whose attitudes regarding insanity in cases where mothers murdered their children was mentioned earlier in this chapter and dealt with in N.Walker, *Crime and Insanity in England Volume I* (see footnote 57).
[164]L.Panigrahi, *British Social Policy and Female Infanticide*, p173.

views of the female's nature and role. Child murder was felt to be such a perversion of these views that it was believed that they must reflect insanity.

CONCLUSION.

Gaol Bahar. Mania. Muss. Beggar. 50. 10 Jan '61.

1861 Janr. This old woman had lived for years in my compound where she considered she had a right to a house in consequence of having been attached to the family of a former resident. Is very restless + excitable. Sings + cries alternately + often makes a frightful howling- busies herself with dusting about the grounds outside the house- is a kind of pensioner. Lately she has become very abusive and strikes the servants + children in the compound- breaks thin earthen vessels + in short has become so troublesome, noisy and destructive that after many threats I have felt myself obliged to shut her up.
May. Since her admission is much subdued. Is very quiet + frequently petitions for release.

December 4th 1865. Died of debility.[165]

Although she is not a member of one of the groups discussed in this chapter it is worth mentioning Gaol Bahar at the beginning of these concluding comments because of the essentially local character of the decisions made about her which have resulted in her admission. Simply, she is incarcerated because she is a personal irritant to the superintendent of the asylum, a bossy old woman attempting to assert her seniority in the household to which she feels entitled by age and length of service but who is ultimately surplus to requirements. Her admission is difficult to explain in any but these terms, there were no meta-narrative preoccupations with old women or those who threatened pottery, her incarceration is explicable in the quintessentially local circumstances of a British official's household and the inconvenience that one individual with the power of incarceration was put to by the behaviour of another.

Studying the admissions policy in the British lunatic asylum system in colonial India in the two decades after 1857 serves to illustrate the importance of power operating at both general and local levels in defining colonial encounters. Problem groups were identified by colonial government and a system of responses was devised by which the population could be disciplined or strengthened by removing those groups. While the figure of the wanderer and the dangerous lunatic as target of government policy can be explained by referring to the anxieties of colonial and modern government the examples in the case notes which show those who ended up in the asylum first being admitted to hospitals, poor houses or idiot wards or simply being passed from police post to police post suggest that the process by which an individual came to be in the

[165]Case Book IA, patient no.76, admitted 10 January 1861.

case notes was far from being a well-defined one and was likely to be the result of a series of local decisions and contingencies.

This seems to have been demonstrated most clearly in the case of the criminal admissions. Although the classification of the criminal lunatic can be tied up with meta-narratives of responsibility and individual culpability central to the contractual culture of modern society,[166] the individuals who ended up in the Lucknow lunatic asylum in this period did so because their circumstances not only put them within this classification but drew them to the attention of the local operators of the legal, penal and policing systems who had their own aims and imperatives worked out from the logic and necessities of their own positions.

The meta-cultural discourses of modernity, patriarchy and colonial insecurity enmeshed to produce figures to haunt and concern the imagination of the British and to become targets of stated legislative and bureaucratic policy. But the selection of the actual individuals who spent part of their life, and often encountered their death (every case note used in the section on non-criminal admissions which includes an account of the patient's fate which could have been either death or discharge, ends in death) in the asylums has been shown to operate within a matrix of locally generated management policies, institutional contingencies and maybe even individual personal preferences which acted to sort through the mass of those who fitted the bill presented by the larger concerns. While the meta-narratives may have defined the person to be admitted to the asylum, the goals and considerations of the operators of the disciplinary apparatus worked within the definitions of those meta-narratives to select the people who actually did end up inside.

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[166]See D.Ingleby, 'Mental Health and Social Order', in S.Cohen/A.Scull (eds.), *Social Control and the State*, pp156-7; R.Castel, *The Regulation of Madness: the origins of incarceration in France*, (Polity Press 1988), pp27-38.

CHAPTER IV.

Disciplining Individuals: treatment regimes inside the asylum.

CHAPTER IV. DISCIPLINING INDIVIDUALS: TREATMENT REGIMES INSIDE THE ASYLUM.

In his overview of the development of mental asylums in India, Shridhar Sharma christens the period from 1858 to 1906 the 'second phase of development' and concludes that "the asylums then constructed were simply places of detention",[1] pointing to "the apathy and indifference on the part of the authorities at that time, to the needs of mental patients".[2] The work of Waltraud Ernst, although restricted to the asylums in British India for European patients, comes to a similar conclusion and she characterises the institutions of the early decades of the nineteenth century as simply "refuges or temporary receptacles".[3]

By focusing on the asylums set up by the British for Indian patients in the period 1857-1880 it becomes possible to point to a more complex role for the asylum in the developing colonial system than that of receptacle or place of detention. A range of therapeutic strategies was devised in the asylums through which it was hoped to supervise and drill the bodies and minds of the Indian patients. Sharma's account of the asylums emphasizes that,

> as medical supervision of some sort was considered necessary in the event of an illness to inmates, the institutions, for the sake of expediency were given over to medical management.[4]

It will be argued here that the medical control of asylums was less to do with such expediency and more to do with a role familiar from recent studies which have identified "colonial medicine as an agency of disciplinary control".[5]

The Western Experience.

It is not just colonial medicine which has been viewed in recent years as complicit in disciplinary projects. Treatment regimes in the asylums of Europe and North America in the nineteenth century have also been accused of being agencies of disciplinary control. Apologists for psychiatry contend that from the middle of the eighteenth century "medical men began to experiment with more humane methods of care and

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[1]S.Sharma, *Mental Hospitals in India*, (Directorate General of Health Services New Delhi 1990), p52.
[2]Ibid., p53.
[3]W.Ernst, *Mad Tales from the Raj: the European insane in British India 1800-1858*, (Routledge London 1991), p166.
[4]S.Sharma, *Mental Hospitals in India*, p52.
[5]D.Arnold, 'The Colonial prison: power, knowledge and penology in nineteenth-century India', in D.Arnold and D.Hardiman (eds.), *Subaltern Studies VIII* (Oxford University Press 1994), p180.

treatment",[6] and that the standard therapeutic approach of the nineteenth century can be characterised as a "gentle régime".[7] This approach, dubbed 'moral treatment', and the various other characteristic responses of medical men to those considered mentally ill have however been the subject of more critical examination over the last thirty years.

Michel Foucault is the best known of those who have pursued a captious line on treatment regimes in the asylums of the nineteenth century. The characteristic treatments of the period were non-restraint, putting to work and physical therapy. To Foucault, these were all part of a process of disciplining the individual interned in the asylum. They worked to limit the non-conformity and individuality of the internee and to impose a bourgeois morality on those who were defying it, those who were lazy, dissolute or promiscuous.

> The asylum reduces differences, represses vice, eliminates irregularities.[8]

Regarding the techniques of non-restraint, which prohibited confinement by apparatus like chains or the strait-jacket and encouraged the asylum staff to approach the patient with kindness and respect, Foucault asserts that "the partial suppression of physical constraint was part of a system whose essential element was the constitution of a 'self-restraint'".[9] Occupational therapy strategies, the putting of patients to work, were similarly disciplinary:

> In the asylum, work is deprived of any productive value; it is imposed only as a moral rule; a limitation of liberty, a submission to order, an engagement of responsibility, with the single aim of disalientating the mind lost in the excess of a liberty which physical constraint limits only in appearance.[10]

When it comes to physical treatments, such as hydrotherapy, Foucault points out that "madness will be punished in the asylum"[11] and that "the use of the shower became frankly juridical; the shower was the habitual punishment of the ordinary police tribunal that sat permanently at the asylum".[12]

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[6]K.Jones, *Asylums and After: a revised history of the mental health services, from the early eighteenth century to the 1990's*, (Athlone Press London 1993), p23.
[7]Michel Foucault (translated by Richard Howard), *Madness and Civilization: A History of Insanity in the Age of Reason*, (London: Routledge 1989), p250.
[8]Ibid., p258.
[9]Ibid., p250.
[10]Ibid., p248.
[11]Ibid., p269.
[12]Ibid., p266.

While many historians have stayed short of adopting the entire Foucauldian analysis many use his idea that treatment regimes were part of the process of controlling and reforming those who did not regulate themselves to ensure that they were orderly and productive.

Andrew Scull for example holds that 'moral treatment', a combination of the techniques of non-restraint and putting to work, "actively sought to transform the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual"[13] and emphasises the Foucauldian idea that moral management was a system born of the conviction that

> men have to be taught to *internalize* the new attitudes and responses, to discipline themselves.

Anne Digby explores the system of rewards and punishments which made up the non-restraint system at the York Retreat in England. The patients were allowed to go about without physical restraint and were treated with kindness and respect in all dealings with the staff. The idea was that the patient was trusted to behave, and this trust was made desirable by linking it with patience and consideration for the patient. The patient would then develop a desire to justify this trust and subsequently to moderate their behaviour to meet the expectations of those treating them so well. She concludes that

> moral management was depicted to the patient as a two-way process that involved both the imposition of a 'moral discipline' by therapists and also the development of a 'self control' by the patient. Eventually, it was assumed that internal restraint would replace external restraint.[14]

Non-restraint was designed to get the patient to go beyond simply obeying commands by those in authority to a state where the patient commanded themself to behave in certain ways and was able at the same time to obey those commands. Quite simply, they were internalizing the moral order of the asylum, an order which was constructed to reflect an idealised version of the social order outside of the walls of the asylum.

Examples from the United States show how the commitment to non-restraint varied and how physical treatments like restraint or bodily coercion were often used simply to enforce obedience or to silence the patient. Nancy Tomes points to what she calls "the

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[13] A.Scull, *Social Order/Mental Disorder: Anglo-American psychiatry in historical perspective*, (Routledge London 1989), p89.
[14] A.Digby, *Madness, Morality and Medicine: a study of the York Retreat, 1796-1914*, (Cambridge University Press 1985), pp72-74.

English consensus on non-restraint"[15] which she attributes to the centralising impetus of the Lunacy Commission in that country, and contrasts this with the American approach: "A style that championed not only the therapeutic value of mechanical restraint, but also the physician's right to prescribe it without external influence".[16] Mary Ann Jimenez provides the example of the McLean asylum in Massachusetts where,

> although this asylum was founded on the precepts of moral treatment, more strenuous and even punitive approaches were evident there from the beginning. Strong rooms, muffs, chair and bed straps, and even manacles were used to restrain patients in the 1820s. Drugs, especially laudanum, were administered; in fact, patients who requested discharge were often administered extra dosages of drugs.[17]

Similarly, Yanick Ripa points out that "debate about the use of the 'no-restraint' approach, which rejected all forms of physical constraint, was not as active in France as it was in England at the same period".[18] Ripa holds that modes of therapy which involved coercion or restraint were simply acts of repressive violence dressed up in scientific garb:

> Treatment or punishment? The two words were in practice so similar that doctors often used them interchangeably. The insane had to be punished for being abnormal, and treated to put them back on the right path. Hydrotherapy was the cornerstone of this repressive treatment..[19]

In Ireland, Mark Finnane finds a similar state of affairs, discovering that, "although a therapeutic rationale had been constructed for the bath, shower-bath and douche (throwing buckets of cold water over the patient), by the 1870s it was commonly considered that they had come to be used 'solely for the maintenance of discipline'".[20] He also shows how the 1860s and 1870s were a period when pharmacological treatment became a means by which patients were controlled.[21]

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[15]N.Tomes, 'The Great Restraint Controversy: a comparative perspective on Anglo-American psychiatry in the nineteenth century', in W.F.Bynum, R.Porter and M.Shepherd (eds.), *The Anatomy of Madness: essays in the history of psychiatry*, (Routledge London 1988), p202.
[16]Ibid.
[17]M.A.Jimenez, *Changing Faces of Madness: early American attitudes and treatment of the insane*, (University Press of New England London 1987), p113.
[18]Y.Ripa (translated by Catherine du Peloux Menagé), *Women and Madness: the incarceration of women in nineteenth-century France*, (Polity Press Cambridge 1990), p123.
[19]Ibid., p123.
[20]M.Finnane, *Insanity and the Insane in Post-Famine Ireland*, (Croom Helm London 1981), p207.
[21]Ibid., p205.

Indeed, Anne Digby shows how even an institute like the York retreat which was regarded as pioneering non-restraint and moral management methods would use techniques like the pharmacological straitjacket to achieve the short term disciplinary goals of silence and obedience in patients. She lists potassium bromide and chloral hydrate as the main sedatives in use from 1858 onwards and quotes a patient who considered the aim of the drugs to be to "'quench the poor sufferers into quietness'".[22]

Certain authors also take Foucault's lead and explore work for patients in the asylums as a disciplinary procedure. David Rothman looks at an American example, of the Pennsylvania Hospital where the superintendent was Thomas Kirkbride, and concludes that when it came to treatment, "of all the activities, asylums prized labour the most, going to exceptional lengths to keep patients busy with manual tasks".[23] Speaking of Kirkbride, Rothman says

> he encouraged his private patients to do any task; it did not matter whether they planted a garden, husked corn, made baskets or mattresses, cooked, sewed, washed, ironed, attended the furnace or cleaned up the grounds. Outdoor chores were probably most healthy and pleasant, but the critical thing was to keep at the job. This regimen, Kirkbride and his colleagues believed, inculcated regular habits, precisely the trait necessary for patients' recovery.[24]

Work had a disciplinary function then, to instil order and encourage application to the methodical, in other words to rehabilitate the patient to the demands of a capitalist economy. Feminist scholars in particular emphasise the importance of work in re-forming those deemed mentally ill, as having the patient perform work proper to their gender reasserted the cultural expectations of their gender over the inmate. It was the very refusal to submit to those expectations in the first place which had occasioned their incarceration as mad.

Elaine Showalter for example, studies the treatment of women deemed mad in England and concludes that "the asylum's program of 'suitable occupations and diversions' enforced habits of steadiness and self-discipline".[25] She contrasts male patients' work, in workshops or on asylum farms, with tasks allotted for the female patients

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[22]A.Digby, *Madness, Morality and Medicine*, pp128-9.
[23]D.Rothman, *The Discovery of the Asylum: social order and disorder in the New Republic*, (Little Brown Boston 1971), p145.
[24]Ibid., pp145-6.
[25]E.Showalter, *The Female Malady: women, madness and English culture, 1830-1980*, (Virago London 1987), p37.

which tended to consist of cooking, cleaning, laundry and sewing, and asserts that "women's occupations were intended to reinforce conventional sex-role behaviour".[26] Yannick Ripa concurs with this from study of French examples:

> Work then was the antidote to pride and ambition, and provided a form of social therapy which put every woman in her place. Working-class women returned to the work they had traditionally done- repetitive and poorly valued jobs like cleaning, washing and sewing.[27]

Whatever the specific focus of historians over the last twenty years then, be it non-restraint, the promotion of work or methods of physical treatment, the conclusion seems to be the same. Whether the aim of treatment regimes was short-term, that is to simply assert the control of the institution over the individuals' behaviour, or more committed and long-term, to make the patient abandon the isolation of their own feelings, perceptions and conclusions and force them to submit to prescribed social roles and to meet standard cultural expectations, is a secondary consideration. Critical historians of asylum regimes all stress the disciplinary nature of the techniques and approaches adopted in the nineteenth century in forcing certain people to adopt certain types of behaviour.

Psychiatry in the Colonial Experience.

Located as it was in the colonial medical system which has been identified as often complicit in disciplinary projects, and drawing on elements of European asylum treatment systems which have also been shown to be involved in such projects, it seems that the therapeutic regimes of insane asylums in colonial encounters between Europeans and non-Western peoples would be an important focus for historians examining the disciplinary techniques and aspirations of colonial government.

What work there is on such asylums though often fails to deal with treatment regimes in such a light. Regino Paular, in looking at the treatment of Filipinos in the Philippines during Spanish colonial rule in the nineteenth century simply concludes that "during the latter part of the nineteenth century, the psycho-medical practice of observing, analyzing, and treating mentally-disturbed Ss in the Philippines had traceable aspects of European schools of thought (e.g.Psychoanalysis), particularly in the use of psychopathological terminologies and in the rudimentary application of the

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[26]E.Showalter, *The Female Malady*, p82.
[27]Y.Ripa, *Women and Madness*, p125.

Catharsis method".[28] In other words his concern is with centre-periphery debates about the transfer of technical knowledge from the metropole to the colonies.

Sally Swartz looks at treatment regimes in the Valkenberg asylum in the Cape Colony and concludes:

> Care for the insane in the Cape asylums during the period 1891-1920 was governed by four principles, which together formed the basis of 'moral management': 'early' treatment, in 'insipient' stages of the illness; classification of patients according to race, gender, and class of disturbance, separating quiet, 'hopeful' and recovering cases from dangerous or disruptive ones; remedial occupation and recreation; and minimal resort to harsher forms of control such as mechanical restraint and seclusion.[29]

However she is not concerned with the objectives of this treatment regime, mentioning 'care' (above) and 'recovery'[30] as the concern of the asylum yet not emptying these words of meanings devised at the time they were used, that is not explaining whether 'care' is an adequate description of the regime or what 'recovery' was understood to involve. This is largely because her project is to explore the experience of everyday life inside the asylum and to show how the racialised and gendered culture outside the asylum was mirrored inside the institution. Despite the focus of her project being those deemed insane of European origin in British India Waltraud Ernst touches on the treatment of Indian patients, although she also limits herself to "the officials' dogged insistence on race-, class-, and gender-specific segregation".[31]

Of all the historians to have worked on issues of lunacy in the colonial context perhaps Megan Vaughan's work is the most interesting when trying to assess treatment regimes in colonial asylums as disciplinary projects. She does not specifically dwell on treatment regimes, but rather her general discussion of Foucault's notions of 'governmentality' has a number of points pertinent to the discussion of such regimes. Her argument is that

> one needs to ask how far colonial states exercised 'productive' as opposed to 'repressive' power. My examination of the operation of biomedical discourse in Africa would seem to indicate that there are real differences between the nature of the colonial power/knowledge regime and that described by Foucault.

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[28]R.Paular, 'Mental Illness as a Social Problem in the Phillipines during the Spanish Colonial Period', in *Philippine Journal of Psychology,* 25, 1, June 1992, p17: The author uses 'S' to stand for a *demente* (person who is mentally disturbed) admitted to the Hospicio de San Jose.
[29]S.Swartz, 'The Black Insane in the Cape, 1891-1920', in *Journal of Southern African Studies*, 21, 3, September 1995, p411.
[30]Ibid.
[31]W.Ernst, *Mad Tales from the Raj*, p79.

> The first is that colonial states were hardly 'modern states' for much of their short existence, and therefore they relied, especially in their early histories, on a large measure of 'repressive' power. Only in some cases, and then only in the later colonial period, and in their liberal, welfarist functions, did they create the systems of surveillance and control common to Europe.
>
> Secondly, and closely related to the first point, the medical power/knowledge complex was much less central to colonial control than it was in the modern European state. Colonial psychiatry did identify the 'lunatic' and sometimes incarcerated her or him ... but in general the need to objectify and distance the 'Other' in the form of the madman or the leper was less urgent in a situation in which every colonial person was in some sense, already 'Other'. This is a recurring theme in the literature on psychiatry in colonial Africa, in which the problem of definition of the 'normal' and the pathologization of that 'normal' African psychology is ultimately more important than the subsequent definitions of the 'abnormal' ...
>
> Thirdly and again related to the last two points, the extent to which colonialism and medical discourse as integral to it, created 'subjects' as well as 'objects' and thus operated through individual subjectivities is open to question, I think. Although a great deal of what I shall call 'unitization' went on in colonial states, this is not the same as the creation of individual subjectivities.[32]

In India it is certainly possible to agree that the state was hardly a 'modern state', especially in the 1860s and 1870s and that it did indeed rely on repressive power for the maintenance of its position. It should also be remembered that the asylums of India were very much a peripheral institutional system, only ever dealing with tiny fractions of the region's total population. However, by examining the treatment regimes of these asylums it seems possible to discern the modernist ambitions of the colonial state even if these were in a context of repressive power, and to find at least the fantasy of producing something new from the racial and rational 'Other'.

Psychiatric Treatment in India.

> The Asylum, I am to remark, should not be merely a place where the insane may be comfortably confined, but a hospital for their treatment and cure.[33]

There is plenty of evidence that the British authorities were intent upon providing institutions in India in which those members of the local populations that they encountered and deemed to be mentally ill would receive treatment with the recovery from their illness as the ultimate goal, the superintendent at Bareilly for example admitting that it was his job to see to it that "in the management of this asylum attention is given to the comfort of the patients as well as to the cure of the disease".[34]

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[32]M.Vaughan, *Curing their Ills*, p10.
[33]'Annual Reports of the Lunatic Asylums at Bareilly and Benares for the Year 1866', in *Selections from the Records of the Government of the North-Western Provinces*, p61.
[34]'Asylums at Bareilly and Benares for the year 1867', p58.

It was suggested in an earlier chapter that 'recovery' or 'cure' in the Indian insane to the eyes of the British was denoted by an exhibition of certain qualities in the individual linked to self-regulation and productivity or what might be described as "the Victorian fetishes, of 'discipline, 'routine', and 'order'"[35] and of course "hard work".[36] Throughout the British administration it was considered self-evident that the best way to set up institutions to effect that state was on the lines followed in the model establishments in the West. On the frontline, superintendents wrote "as we have now a good working establishment, I hope that we shall be able to carry out still further improvements, and in time bring the Asylum as near to the English standard as the circumstances of the country admits",[37] while those nearer the top of the colonial bureaucracy also recognised that

> everything that constitutes a remedial institution on the modern European footing has to be introduced and exercised for the first time. The classification of the insane, the regulation of their common social life under the cottage system, their recreation, their education, their cure, their employment in various descriptions of appropriate labour, all the processes of benevolence and science have to be studied and carried into effect.[38]

As such it is no surprise to see the virtues of non-restraint, gentle treatment and the reintroduction to labour being extolled in the asylum reports:

> Herein lies the foundation of the good management of a Lunatic Asylum for natives. The hope of release, avoidance of everything that might annoy or vex the patients, unremitting watching, and silent attention to their complaints and ramblings will gain perfect control over the noisiest and most troublesome. The unreal and often rude speech must be borne, because to attempt corrections or to be angry with them will only aggravate and destroy control over the patient.
>
> I believe that by scrupulous cleanliness, liberal diet, affording them means of recreation or occupation, and attention to all the functions of the body are the foundation of the medical treatment and moral management of lunatics.
>
> The insane are not slow in sagacity and the power of comprehending what is done for their good and thus will appreciate kindness.[39]

The way in which the British medical officers used the therapeutic regimes developed in nineteenth-century Europe to assert themselves and their agendas over the bodies

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[35]D.Chakrabarty, 'The Difference-Deferral of a Colonial Modernity: public debates on domesticity in British Bengal', in D.Arnold and D.Hardiman (eds.), *Subaltern Studies VIII*, (Oxford University Press 1994), p55.
[36]Ibid.
[37]*Annual Report on the Lunatic Asylums in the Punjab for the Year 1879*, p3.
[38]Minute by President Madras 29 October 1865 GOI (Public) Procs, 27 February 1869, 105-107A.
[39]*Asylums in the Punjab for the Year 1871-2*, p5.

and minds of those who came under their jurisdiction in the asylums will be explored by examining the two stages in the process of assertion: control and reform.

Controlling the Indian inmate.

> It must not be supposed, because the labor of an asylum is rightly called voluntary, that the character of a Native, naturally indolent and now exalted by mania, or depressed by melancholy, is of necessity by admission to an Asylum, in a moment so transformed that industry becomes a pleasure to him. It is of the essence of his treatment that he be brought, by resolution of purpose and persistent effort, within the discipline of the place if he do not at once conform to it ...[40]

The first task for the medical officer on being confronted by a new inmate was to establish authority over that individual and to ensure that their behaviour and body met a basic standard from which the procedures of reform could take place. The body was the first site to be prepared.

The body.

> On a patient being brought to the asylum he or she is placed in a single room for two or three days, well washed, carefully fed, the state and condition of the excretions and secretions examined... where there is any obvious bodily disorder found to exist, appropriate medicines are prescribed for its removal ...[41]

The body was to be ordered and made efficient through the regulation of its functioning, so cleanliness and eating were emphasised and the working of the body was closely observed. "Every patient is daily bathed",[42] insisted the superintendent at Cuttack and the superintendent at Dacca elaborated on the regime in his institution: "The lunatics, both males and females, are bathed daily ... The dirty and intractable patients are rubbed with khullee (mustard oil culee) made into a thin paste with water and then washed under the shower bath. This cleanses the skin and leaves it soft, and is better than soap which makes the skin dry ... one of the day keepers is particularly set apart for the bathing duties".[43] The suggestion that cleanliness was imposed on the patients comes through even more clearly in the assertion of the Surgeon-Major at Delhi who stressed that

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[40]*Annual Report of the Insane Asylums in Bengal for the Year 1863*, p3.
[41]*Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency for the Year 1873-4*, p4.
[42]*Asylums in Bengal for the Year 1867*, p93.
[43]*Asylums in Bengal for the Year 1862*, p29.

> cleanliness is enforced both as regards the wards, the grounds and the persons of the lunatics. Nothing can prevent entirely some of the most debased of the lunatics from being guilty of filthy actions, but they are cleaned and washed and all traces of pollution at once removed.[44]

Coercive measures were also used to ensure that a patient's reluctance to feed or be fed was overcome. The superintendent at Colaba reported in 1875 that

> there were 6 cases of refusal of food. One was of a very obstinate and protracted nature in a young Parsi suffering from acute mania; he had to be fed with the stomach pump regularly for about two months; he was in consequence very much reduced. One day he was accidentally given some beer, which had the desired effect, as he began to eat soon after of his own accord.[45]

Indeed, the administration of nutrition could be even more violent still: "Tea was also given by injection through the rectum".[46] In other words patients had no control over their own intake, their diet was determined by the colonial medical officer which was then forcibly administered if necessary.

The body was not just subjected to washing and feeding, it was also deliberately rested. Dr. Wylie at Ahmedabad is frank in accounting for his use of certain drugs, "Hydrate of Chloral ... is a useful addition to the available means of controlling insomnia".[47] The medical officer in charge of the asylum at Moorshedabad mentions, "the administration of Morphia to allay undue excitement and procure sleep"[48] and the superintendent at Madras notes that "a little wine or arrack at bedtime induces a quiet sleep, and I do not consider the use of opiates desirable where simple means can be employed to effect the desired result".[49]

Perhaps most significant of all in light of the earlier discussion, it appears that vaccination was often enforced. David Arnold has demonstrated that vaccination in

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[44] *Asylums in the Punjab for the Year 1874*, p1.
[45] *Asylums in the Bombay Presidency for the Year 1874-5*, p13.
[46] *Asylums in the Bombay Presidency for the Year 1873-4*, p3: The decision to administer 'beef-tea' may have been taken as the patient in question was a Parsee rather than a Hindu. However it does seem to be an odd choice given the attitude of certain sections of the Indian community to vegetarian diets and cow products, so the decision to use the preparation may have reflected the ignorance of British medical officers about Indian diets or indeed may suggest something altogether more disciplinary. The superintendent may have had Eurocentric convictions about the benefits of meat in a diet and could have been attempting to force 'beef-tea' into the body against the will of the Indian patient in the belief that the Indian body must be built and formed as the British wished it to be even if the Indian individual wanted to resist that form.
[47] Ibid, p32.
[48] *Asylums in Bengal for the Year 1862*, p66.
[49] *Annual Report of the Three Lunatic Asylums in the Madras Presidency during the Year 1873-4*, p19.

the prisons of India was an unashamed assertion of the colonial will as, "at a time when vaccination against smallpox still encountered strong resistance and evasion in India, it was compulsory for prisoners".[50] John Murray at the asylum in Madras mentioned that "vaccination has been carefully attended to"[51] and Arthur Payne in Calcutta indicates that not much choice was given to the patients: "Vaccination has been practised in every case".[52] In the Bombay Presidency,

> at Ahmedabad and Hyderabad all the inmates are protected; but although the other Superintendents make no mention of vaccination, the fact that there has not been a single case of small pox recorded from any of the asylums even during a period when that disease was exceptionally prevalent elsewhere, and even in their vicinity, would seem to point to the effectual measures of protection having been adopted by all.[53]

These processes were all accompanied by close surveillance of the body in order to gauge its progress towards a certain standard. In his report of 1872 Dr. Penny at the Delhi institution notes the importance of physiological surveillance, or what he calls "carefully watching all the functions of the body".[54] One way to give this surveillance a scientific and empirical footing was devised in the Madras Presidency:

> In 1874 I ordered the introduction of the system of weighing the patients monthly. This has been attended with great advantages, as an inspection of the register at once attracts attention to any patient needing care on account of deterioration of general health, or who may require a change of diet.[55]

Overall then the policy of the medical officers was to tend to the patient's physical state, and this could easily be seen as an act of benevolence or just good sense on the part of officials dealing with admissions who were often starving or ill: "A very large proportion, however, of our patients require no other treatment than good feeding".[56] Indeed, the emphasis on the physical may also simply reflect the theoretical limitations, mentioned in an earlier chapter, of doctors whose stock in trade it was to deal with the body rather than the mind.

However, it is necessary to consider more extreme examples of the medical officer at the asylum asserting himself over the body of the Indian inmate in order to fully

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[50]D.Arnold, *Colonizing the Body: state medicine and epidemic disease in nineteenth century India*, (Oxford University Press 1993), p108.
[51]*Asylums in the Madras Presidency during the Year 1873-4*, p22.
[52]*Asylums in Bengal for the Year 1868*, p3.
[53]*Asylums in Bombay for the Year 1876*, p9.
[54]*Asylums in the Punjab for the Year 1871-72*, p3.
[55]*Asylums in the Madras Presidency during the Year 1875-76*, p11.
[56]*Asylums in Bengal for the Year 1862*, p66.

comprehend the project of the colonial in treating the patient's physique. Consider, for example, treatments like that meted out to the patients in the asylum of the Civil Surgeon of Rangoon.

> The very obnoxious practice of masterbation [sic] which is the cause of insanity in many cases, and which aggravates the disease, is very common amongst the inmates of the asylum here. I have perplexed myself about the vice and in former years endeavoured to prevent it by blistering the penis with crotenal etc., but without effect, and various medicines were given in vain with the view of moderating or repressing the desire.
>
> During the past year I have tried Dr. Yellowless's mode of prevention very recently practiced in asylums at home, and so far as it has gone, I am very much satisfied with the result.
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> The suggestion was founded on the anatomical fact that the prepuce was anatomically necessary for the erection of the penis. Its anatomical use was to give a cover for the increased size of the organ. If you prevented the prepuce going to that use, you would make erections so painful that it would be practically impossible, and emissions therefore unlikely.
>
> The operation is very simple: the prepuce at the very root of the glans is pierced with an ordinary silver needle, the ends of which are tied together.[57]

This is an overtly and explicitly disciplinary measure in the context of which the control assumed by the medical officer over the feeding, the cleaning, the sleep, and the blood of the asylum patient can be better understood. The legitimate use of the Indian's body was being decided by the British officer, the superintendent was assuming control of the inmate's physique through the infliction of pain and depriving him/her of the right to decide what to do with it. The Indian was being denied access to his/her personal physical experience of the world and was being prevented from using his/her own body to convey their own messages or satisfy their own desires. Quite simply the Indian inmate's body had been colonized and it was to be disciplined. The colonisers had their own ideas about what should be done with the body of the Indian whom they considered insane. These ideas are evident in the description of recovery on the case note of Mukhsoodally Khan, who was admitted for mania and suffered an attack of fever:

> For several months past this man has improved in health, has been quiet + well conducted and assisted in the garden- he is stout and strong- all bodily functions properly performed + he does not appear to be labouring under any delusion. His relatives are anxious to remove him + I therefore, as he has been well for months, discharge him cured.[58]

There is no reason on a document on which information is contained about an individual who was thought to be suffering from mental disorder to include all that

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[57]Civ.Surg.Rangoon to IMD.Burma 15 January 1877, GOI (Medical) Procs October 1877, 18-20B.
[58]Case Book IA, patient no.114, admitted 8 June 1861.

information about the man's physical condition unless it is considered significant evidence in connection with the decision to discharge. If it is significant evidence in connection with the decision to discharge then it must be because it is indicative of the man having achieved the condition desired by the asylum. In other words, the asylum was seeking to produce stout, strong and ordered bodies, the result of all that feeding, cleaning and chemical treating. Asylum medicine seems equally as disciplinary as colonial medicine as a whole then, in as much as it functioned to produce or drill bodies that could prove useful in a colonial system.

The mind.

The production of a disciplined body was not the only end to which the efforts of the asylum were directed. The behaviour of the patient, 'exalted by mania or depressed by melancholy' needed to be similarly brought within the discipline of the asylum and under the control of the superintendent before the more complex procedures of reform could be attempted. This would consist of rousing or subduing the patient according to whether the patient was withdrawn and unenthusiastic or over-excited and animated.

Official policy in this period was to follow European theories of controlling the patient through kindness and coaxing. In 1877 it was written in an end of year report that

> the system adopted in the asylum is what is called the 'non-restraint' system, the object of which is the humane and enlightened curative treatment of the insane. As is well known, this system was inaugurated by Pinel and Esquirol in France and by Charlesworth, Hill and Connolly in England.[59]

Almost ten years earlier the elements of 'humane and enlightened' approaches were described by an asylum superintendent in the North-West Provinces: "Harshness and violence form no part of the system; coercion is seldom if ever resorted to; and the inmates are managed and quieted entirely by kindness, firmness, order, regularity and occupation".[60]

Despite this rhetoric though restraint and violence in a variety of forms were sanctioned by the medical officers in charge of the institutions. There were superintendents who simply ignored fashionable opinion and went ahead with

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[59] *Asylums in the Madras Presidency during the Year 1877-78*, p12.
[60] *Asylums at Bareilly and Benares for the Year 1867*, p58.

mechanical restraint: "When refractory patients are confined in these wards it is generally found necessary to secure them with strait waistcoats, as most of them are very destructive".[61] Surgeon-Major Payne in Bengal was similarly dismissive of non-restraint although he was more concerned to justify his opinions.

> So much has been said and written of late years respecting the treatment of lunatics without personal restraint, and popular feeling has been so largely enlisted in its favour, that non-restraint has given its name to the modern system and has come to be an expression for every thing that is kind and humane, while all that savours of restraint is condemned in the popular mind as belonging to an age of barbarism ... It would seem however that the time has now come when it may be said, without fear of outside indignation, that personal restraint is good or bad in the absolute, precisely as it is good or bad in the individual subjected to it.[62]

He goes on to describe "fixing the maniac on a mattress, with a broad sheet covering his entire body" and "a long canvas bag with a collar fitting loosely on the neck, sufficiently wide to prevent any active or dangerous movement of limbs ... this bag envelopes the whole person except the head, and its edges are made fast by strong tapes to the cot on which the mattress is placed".[63]

Other officers decided to devise alternative ways of achieving control over the excited patient's behaviour and in effecting desired changes in the inmate's conduct. In the asylum at Colaba the superintendent exposed in a sentence how medical officers could overcome the restrictions on restraint and devise acceptable ways of punishing errant behaviour in patients.

> No mechanical restraint is adopted in the treatment of violent or unruly patients. Such patients are placed in one of the dark, boarded cells, or merely shut up for a few hours in an ordinary room until the excitement subsides.[64]

Exclusion and isolation to chastise and frighten the inmate were adopted rather then direct physical contact. Indeed this example from Colaba is particularly interesting as on the same page of the report the superintendent stated that "I have no remarks to make on the criminal lunatics, excepting on one who is noted for effecting his escape from jails and once from the asylum. On this man's legs irons are kept". It would seem that in certain cases where forcible restraint was used it was simply not mentioned as part of the treatment regime.

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[61] *Asylums in the Punjab for the Year 1871-2*, p1.
[62] *Asylums in Bengal for the Year 1868*, p3.
[63] Ibid.
[64] *Asylums in the Bombay Presidency for the Year 1873-74*, p4.

Elsewhere the system of exclusion and isolation was favoured by medical officers as a way of asserting their authority over disruptive or undesirable behaviour, as Surgeon-Major Fairweather revealed in the Punjab: "Restraint has seldom been resorted to and when necessary, nothing more has been done than to lock up a refractory lunatic for a few hours, or at most days, in a solitary cell until he has quieted down".[65]

Indeed, medical officers had recourse to other strategies to temper and restrict the physical behaviour of the inmates. These strategies were available in pharmaceutical form. The superintendent at Calicut admitted that "the treatment has consisted in subduing great mental excitement by large doses of bromide of potassium, hydrate of chloral, morphia, and lately tincture of digitalis has been tried".[66] There was a similar enthusiasm for the chemical straitjacket elsewhere in the Indian asylum system, the doctor at Dullunda asylum near Calcutta for example reported that

> digitalis and hydrocyanic acid have been largely used in the treatment of maniacal phrenzy, and the hypodermic injection of morphia has at times appeared more powerful than either. The latter is indeed seldom without beneficial effect.[67]

Such procedures were the first step that the British officers took in asserting control over the behaviour of the Indian patients, it was the medical men who were dictating acceptable behaviour and using various means of restraint to restrict the possible modes of expression available to the Indian patient. The next stage came when the medical officers attempted to punish or attack aberrant conduct through a series of shocks.

Consider the following case note:

> Lalooie. f. mania. Mussul. Dullal. 30. 6 March 1862
>
> October. This woman was sent in by City Magistrate, stated to be her first attack of insanity, but I had her as a Lunatic patient in the Jail Hospital three years ago before the establishment of the present asylum. She then suffered for months from acute mania.
>
> On admission she was very violent + excited, would not wear clothes, tore everything to pieces + struck + bit every body approaching her. It was necessary to put her under restraint, a Blister was applied to the nape of her neck + sharp purgatives administered. Gradually the violence of the symptoms began to subside- she took to the spinning wheel + for the last two months has been well conducted + quite rational.

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[65] *Asylums in the Punjab for the Year 1877*, p18.
[66] *Asylums in the Madras Presidency during the Year 1877-78*, p6.
[67] *Asylums in Bengal for the Year 1867*, p15.

Discharged cured, October 21 1862.[68]

In the case of Lalooie the stages between excitement and passivity and obedience are restraint and then blistering and purging. A similar impact can be seen in the case of Mhiboobun: "On admission was very sulky and refused her food. Afterwards became violent and tossed about her head and arms, blister was applied and aperient given. Since then has been quieter and takes her food well".[69]

The techniques mentioned in these case notes did have medical justifications. Blistering could be defended as a 'counter-irritant' in the belief that active disease in one part of the body would draw away morbid action from the brain.[70] Purgatives or aperients were a means of controlling body fluid flows by forcing the opening of the bowels and inducing defecation. However the moment at which they are introduced in the case of Mhiboobun, only when she has become violent, suggests that the shock for the patient of being assaulted by a British medical officer by having him blister the neck and cause the patient to suddenly empty her bowels was being used as a tactic by the doctor to counter paroxysms of excitement. Pain and shame were weapons in the armoury of the asylum superintendent in confronting behaviour he considered undesirable.

An excellent example of the medical officer's awareness of the efficacy of such treatments as disciplinary techniques comes from elsewhere in the colonial system. The Commissioner of Rawul Pindee summarised the case of the death of Mir Baz in a letter to the Punjab Government.

> Dr. Lyons caused an enema to be administered in his own presence to a Pathan prisoner, who pleaded epileptic fits as a reason for not working. It may be assumed that the man was a malingerer, and that he had not had any such fits. Dr. Lyons evidently considered the man to be shamming, and he adopted the enema, knowing it to be the most hateful infliction to a Pathan as a punishment and means of curing him of malingering. The man died three days after ...[71]

The enquiry into this death conducted by the Government of the Punjab revealed further facts. It had taken two members of staff, the Native Doctor and the Medical Dresser to administer the enema: "The instrument used was Read's patent enema ... the place where the enema was administered was the open yard in front of the solitary

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[68]Case Book IA, patient no.175, admitted 6 March 1862.
[69]Case Book IA, patient no.56, admitted 24 September 1860.
[70]A.Digby, *Madness, Morality and Medicine*, p128.
[71]Comm.Rawul Pindee to Gvt.Punjab 2 January 1869, GOI (Judicial) 22 May 1869, 86A.

cells".[72] This last detail caused a little unease even amongst the British officials of the period as a report noted that "Dr. Lyons appears further to have acted with impropriety and harshness in having the enema administered in public, instead of within the patient's cell, or in the hospital".[73]

Indeed, when Dr. Lyons himself was asked to report his actions he wrote a letter to the Assistant Commissioner of Rawul Pindee giving the following account:

> I considered the man was a malingerer, and applied the most disagreeable treatment appropriate for epilepsy; for this reason if the man be really ill the treatment will do him no harm; if he is malingering the treatment will still do him no harm, and be appropriate punishment. This is the orthodox rule for the treatment of malingering and has been followed by me in doubtful cases both in the Army Service as well as in this and other Jails. I ordered the man to have an injection of warm water to clear out his bowels ... Yesterday morning I observed this man had been taken into hospital; he looked depressed and crest-fallen which I thought only natural after the treatment... I at once remembered that I had ordered an injection for this man about four days ago, which I am perfectly well aware is offensive to Puthans ... the Native Doctor reported to me, at my house, that he had died about 6 o'clock, and that he did not think that he had died from illness, but from grief or shame.[74]

The enquiry decided that post-mortem examination of Mir Baz revealed signs of peritonitis in the gut and that the enema was not likely to have been the cause of death. However, what this set of correspondence does prove is that there were certainly medical officers who were not simply aware of the disciplinary possibilities of medical therapies at their disposal, but that there were medical officers who were happy to use those therapies as overtly punitive measures. Dr. Lyons' intention in ordering the enema was *solely* disciplinary as he did not even consider Mir Baz to be ill and indeed exhibits a certain satisfaction at having rendered the prisoner depressed and crest fallen. The public administration of the enema was designed to shame the individual, as if being treated by Read's patent instrument was not degrading enough, and of course to inflict discomfort or even pain as a sharp rebuke to the patient's behaviour (that Mir Baz suffered physically during his ordeal is attested to in the evidence of Motee Singh, the Native Doctor, who pointed out that he vomited while the enema was being pumped in). Quite simply, this is an excellent example of a Civil Surgeon, of which many were asylum superintendents, admitting that he had gladly used a medical procedure as a disciplinary technique and that it was certainly not the first time that he had done so. That this came to light at all was only down to that fact that the victim had died in this instance.

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[72]President Committee of Jail Enquiry to Gvt.Punjab 7 August 1869, GOI (Judicial) 9 October 1869, 27A.
[73]Gvt.Punjab to GOI 17 August 1869, GOI (Judicial) October 9 1869, 26A.
[74]Civ.Surg.Rawul Pindee to Asst.Comm.R.P. 21 July 1868, GOI (Judicial) 22 May 1869, 86A.

The case of Mir Baz is not just useful in providing context for the strategies of the medical officer in the asylum as it also demonstrates that medical officers were not simply concerned to calm excited individuals but also to invigorate the inactive or work shy. In asylum practice this meant dealing with those diagnosed as suffering from dementia. "Much active exertion has accordingly been displayed by the staff and attendants in endeavouring to rouse the listless and apathetic",[75] declared one superintendent while another recounted some of the details of the process of 'active exertion':

> A strong water douche, by means of the hose of the small hand fire-engine pump, was tried in two cases with success in rousing the dormant senses.[76]

The following case note shows the failure of painful intervention to stimulate a depressed and melancholic patient.

> Maraie Singh. dementia. Hindoo. Service. 30. 9th May 1861
>
> 1861 May. From Sooltampore. This is believed to be his first attack but of 5 years duration. Is very silent + has a very hang-dog expression. General health appears good.
>
> Sept. In the rains a seton was put into neck, he whined like a baby + cried whenever it was dressed. He is now able to feed himself + has not quite so much misery depicted in his countenance. Quiet and silent as ever.
>
> Oct. Suffered from diarrhoea but got well. Afterwards in December had a relapse which lasted about 25 days and carried him off.
>
> Died Jan. 1862.[77]

Whether the patient was violent and demonstrative or feeble and distracted the medical officer would attempt to control and manipulate their behaviour through a series of assaults on their mind and body. These were designed to shake and shock them from own ways of interacting with the world and make them more amenable to the reforming programmes of the institution, or as the medical officer would have it, "to

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[75]Civ.Surg.Rangoon to IMD.Burma 15 January 1877, GOI (Medical) October 1877, 18-20B.
[76]*Asylums in the Bombay Presidency for the Year 1873-74*, p3.
[77]Case Book IA, patient no. 103, admitted 9 May 1861: a seton was a thread or tape drawn through a fold of skin to open and keep open a small wound through which a discharge could be maintained. This was another means of 'counter-irritation', a treatment pursued in the belief that active disease in one part of the body would draw disease from other parts of the body. The reasons for using it in this case are obscure and the reaction of Maraie Singh suggests that he certainly experienced it as a disciplinary measure even if it was not intended as such.

afford in fact any means of escaping from themselves for ever so brief a period, and turn the current of their thoughts into a more natural and healthy channel".[78]

George Smith, writing in the *Annual Report on the Three Lunatic Asylums in the Madras Presidency* in 1877, excused the use of such measures by reference to the experts.

> Even the humane Pinel did not hesitate to resort to coercive measures and the experience of men of very high authority in this department of practical medicine, have put on record many cases to show that turbulent lunatics have often been made to act in a becoming manner by treatment which assumed a more or less penal character.[79]

Bizarrely, such a passage anticipates, almost exactly, the conclusions of Michel Foucault who wrote of the "paradoxes of Pinel's 'philanthropic' and 'liberating' enterprise, this conversion of medicine into justice, of therapeutics into repression".[80] While the seton and the blister, morphine and solitary confinement, the bag and the strap-down bed may have had medical justifications there is plenty of evidence that suggests that they were used as disciplinary measures, that medical officers had disciplinary intentions and that the net effect of these measures was to control and punish the behaviour of those that the British encountered as insanes in the asylums. The example of Maraie Singh who cries and whines at the application of a seton shows that such measures were certainly experienced as if they were punishments, a point that Frantz Fanon has made elsewhere about the perception of colonial interventions made under the banner of medicine:

> In the colonial situation these things assume a special significance, for the colonized interprets this medical injunction as a new form of torture, of famine, a new manifestation of the occupant's inhuman methods.[81]

Reforming the Indian inmate.

Having gained control of the inmate the next problem for the superintendent was how to get the patient to 'recover', that is as was mentioned above, how to make of the patient an ordered, productive individual.

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[78] *Asylums in the Madras Presidency during the Year 1877-78*, p11.
[79] *Asylums in the Madras Presidency during the Year 1876-77*, p22.
[80] M.Foucault, *Madness and Civilization*, p266.
[81] F.Fanon, 'Medicine and Colonialism', in J.Ehrenreich (ed.), *The Cultural Crisis of Modern Medicine* (Monthly Review Press New York 1978), p249.

A potent indication of the ambitions of the asylum superintendents is in their conceptualization of the asylum and the inmate. Dr. Payne in Bengal conceived of the recovering patient as developing like a child:

> Practically the simplest and most rational plan is to endeavour to revive the brain from decay by imitating the course of nature in its original growth. Habits and associations are the soil in which the ideas of childhood first spring up and in proportion to the care with which the former are regulated will be the soundness of the latter. It is through the discipline and exercise of the body that this end is achieved, and the organic functions of the brain developed, on the perfection of which, after bodily maturity the growth of understanding begins ... the damaged organ is the last that should be laid under forced requisition during disorder. If this be done there is danger of imitating the well known results of urging the education of children prematurely.[82]

In a related vein, Dr. Wylie at Ahmedabad liked to think of the asylum as a 'well-regulated household' in that "discipline and order are successfully maintained under a homely system of kindness, blended with firmness as occasion may demand; and, as a rule, the asylum is ordinarily as quiet and orderly as a well-regulated household".[83]

The asylum was conceived of as a 'home' and those in it a family in which the patients were the 'children' and the colonial representative the 'father'.[84] This construction of the Indian patient is significant because of the colonial setting of the asylum where the 'native' was often construed as a child in relation to the fully developed adult that was the Western man.[85] It is also a construction which is familiar from asylums in the European context, where there was "the prevailing view of patients as being in a state of childhood dependence"[86] and "everything at the Retreat is organized so that the insane are transformed into minors".[87] Quite simply, this positioning of the Indian patients in a relationship of tutelage to the colonial officer in the asylum reports demonstrates the superintendent's self-image as one whose duty it was to 'bring up' the Indian patient. Having established in their own minds the correct relationship in the asylum between the colonial medical officer and the patient, the medical officers

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[82] *Asylums in Bengal for the Year 1862*, p15.
[83] *Asylums in the Bombay Presidency for the Year 1873-4*, p16.
[84] Consider the paternalistic tone of Dr. Penny; 'Luxuries in the way of sweetmeats and fruit and the remains of public suppers have been constantly given in my own presence and by my own hands', in *Asylums in the Punjab for the Year 1870*, p3.
[85] See for example, L.Zastoupil, *John Stuart Mill and India*, (Stanford University Press 1994), p175; A.Nandy, *The Intimate Enemy: loss and recovery of self under colonialism*, (Oxford University Press), pp11-16.
[86] A.Digby, 'Moral treatment at the Retreat 1796-1846', in W.Bynum, R.Porter and M.Shepherd (eds.), *The Anatomy of Madness: essays in the history of psychiatry*, volume II, (Tavistock London 1985), p68.
[87] M.Foucault, *Madness and Civilization*, p252.

developed a regime to facilitate 'recovery' in the patient based on the performance of productive tasks.

Work was both the means and the measure of 'recovery' in the inmate. Dr. Holmsted insisted, for example, that "our chief means of cure is labour: if we can persuade a lunatic to labour, we have hopes of him".[88] Through exposure to work it was thought the Indian inmates would become familiar with what were described above as the 'Victorian fetishes' or what one of the superintendents in the Bombay Presidency called "such wholesome influences as obedience, regularity, forbearance, mutual assistance, diligence and industry".[89] In submitting the patients to labour, "none are allowed to be idle",[90] insisted the superintendent at Delhi, the medical officers hoped to effect the 'recovery' of the patients, that is to reform them into ordered and productive individuals.

The asylum reports also indicate that 'improvement' and 'recovery' in a patient were only recognised by the British medical officers when the patient began to work. One medical officer asserted that

> all the Insanes are encouraged to engage in work as much as possible and they generally do so willingly. On first admission many sit idle but the force of example induces them speedily to join in assisting their brother unfortunates. It is indeed one of the first marked symptoms of improvement when, from sitting in an idle, listless, unobservant mood, they betake themselves to work.[91]

The superintendent at Hyderabad went further than this, stating that "nothing looks so hopeful as regards recovery as getting them to work".[92]

In this way work was central to the modes of treating the Indian inmate as it became, in the phrase coined above, both the means and the measure of 'recovery' in the patient. The British wanted patients to be re-formed into useful and productive individuals by learning the virtues of obedience, regularity, forbearance etc. through constant work and the medical officers also used that constant work as an indicator of a patient's 'recovery' in as much as the individual's progress towards the re-formed, 'recovered' state was signified by the frequency with which work was undertaken.

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[88] *Asylums in the Bombay Presidency for the Year 1874-5*, p28.
[89] *Asylums in the Bombay Presidency for the Year 1873-74*, p16.
[90] *Asylums in the Punjab for the Year 1876*, pp18-19.
[91] *Asylums in Bengal for the Year 1862*, p66.
[92] *Asylums in the Bombay Presidency for the Year 1873-74*, p44.

Crucially though the asylum regime hoped to do more than have the patient submit to its work regimes, the fantasy was that he/she would be, in the words of the superintendent of Dullunda mentioned above, "so transformed that industry becomes a pleasure to him".[93] This fantasy is expressed elsewhere, John Balfour the Inspector General of Hospitals in the Dinapore Circle deciding that

> I need only add that not only should there be nothing penal in the work undertaken, but the patients should learn to look on it as a privilege.[94]

It can also be seen in asylum reports which produce images of the patients "singing blithely at their task",[95] or which exclaim: "I must say I never saw a more happy or contented looking set of lunatics; they work both in the gardens and at the looms with pleasure to themselves".[96] To this end

> compulsory efforts and punishment for not working have been studiously avoided; at the same time every inducement by humouring their fancies, and granting them some coveted indulgence in diet, extras etc. have been employed so as to form a habit; sometimes, when other means have failed, they have been kept with the working party unemployed, and have of themselves taken to work from seeing others employed.[97]

In other words the patients were expected not to have to be compelled to work but to wish to work and to learn to want to work, and this was to be achieved through the tactics of peer pressure or the offering of incentives. The ultimate aim was a *self*-disciplined Indian.

Yet systems of labour were designed to do more than simply take those Indians incarcerated in the institution and turn them into willing workers. The allocation of tasks by gender in the asylum underlines this. At Hyderabad in 1875 Dr. Holmsted summarised that "our chief work is employment in the garden for males, and for females grinding the corn required for the asylum",[98] whereas in the previous year he had included more detail.

> The women grind all the grain required in the asylum, they keep and clean their own quarters, fetch their drinking water etc.; the men are employed in cultivation, making drains, turning

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[93] *Asylums in Bengal for the Year 1863*, p3.
[94] *Asylums in Bengal for the Year 1862*, p72.
[95] *Asylums in the Bombay Presidency for the Year 1873-4*, p29.
[96] *Annual Inspection Report of the Dispensaries in Oudh for the Year 1872*, p299.
[97] *Asylums in Bengal for the Year 1862*, p30.
[98] *Asylums in the Bombay Presidency for the Year 1874-5*, p28.

> water-wheels, attending bullocks, levelling ground, working in the cook-room, brick making.[99]

Similarly, at Delhi, "no manufactures have been attempted, but the males have been employed in gardening, in keeping the ridges and walks neat and trim, and in any other light labour they could be induced to turn their hands to. The women do a little spinning of cotton thread".[100] A strict division of labour was being enforced in the asylums by the medical officers, the emphasis was on women performing domestic tasks and men executing outdoor work involving agriculture and rudimentary construction.

It is interesting to speculate that the types of work that each gender was expected to perform reflects an Orientalist image of Indian society, an image Ronald Inden has christened 'Village India'. He describes this as the British conviction that India was a society of small, independent, agricultural units where "each village was an inner world, a traditional organic community, self-sufficient in its economy, patriarchal in its governance ... a natural, organic and stable community of subsisting peasants".[101] It could be then that the British were attempting not simply to re-form those they deemed mad in Indian society into productive individuals, but into types which were consonant with a colonial construction of pastoral harmony.

What is certain though is that the gendered division of labour was intended to reinforce sex identities that the British thought proper. This is an idea familiar from the discussion of asylum regimes in Europe in an earlier chapter. Indeed, much of the asylum regime served to emphasise gender distinction. It was a matter of course that women's wards were separated from the male ones, as emphasised at Poona where

> the construction of the asylum provides for the complete separation of the female patients in a distinct ward. Three other compartments, communicating with the central hall or keeper's room, are set aside, one for criminals, another for cases of amentia and dementia, and the third is occupied by the stationary and generally quiet class.[102]

Surgeon-Major Taylor at Delhi revealed a further practice that emphasised sexual difference: "The diet scale is the same as it was last year. I think that the women should have more food. I recommended last year that they should have the same

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[99] *Asylums in the Bombay Presidency for the Year 1873-4*, p45.
[100] *Asylums in the Punjab for the Year 1875*, p3.
[101] R.Inden, *Imagining India*, (Blackwell Oxford 1990), p133.
[102] *Asylums in the Bombay Presidency for the Year 1873-4*, p30.

quantity as the males".[103] Dietary practices in the asylum also represented British ideas about what India was and what it should be in other ways, the superintendent at Dacca referring to "cooking, which is carefully done: lunatics assist in both the Hindoo and Mussulman cookrooms",[104] and Surgeon-Major Niven at Colaba including the details that

> the 1st class includes Europeans and Eurasians, and the nature of the diet is the same as that supplied in European regimental hospitals; the 2nd class includes Parsees, native Christians of all sorts, mixed races and a few non-descript people who are fond of changing their character, and wish to be a Christian one day and a native another; the 3rd class consists of Hindus and Mahomedans, and the diet is composed of flour, rice and dhall, and a small quantity of meat and vegetables; the diet of the 2nd class contains baker's bread, tea and sugar, milk and meat, as well as rice and dhall. The native Christians and Parsees are very fond of tea, and it would amount almost to an act of cruelty to deprive them of that article of diet.[105]

In other words the asylum was also arranged to reproduce the British belief in the separateness of the races and in some cases even of the Hindu and Muslim communities and to emphasize to the inmates of the asylum that observance of that separation ought to be maintained. What is especially intriguing about the above passage is the suggestion that while in some asylums there was a separation of Hindu and Muslim diets in Colaba there was not and indeed meat was administered to all. If this was the case then it seems that the superintendent's conviction that he ought to be turning out healthy physical specimens, a state which he considered to be dependent on the inclusion of meat in the diet, had meant that he attempted to impose such a diet on those Indians who may well never have experienced meat and who could have had cultural and religious reasons for not wishing to do so.

Overall then, the asylum treatment regime, and work especially, was devised not simply to turn out productive individuals but certain types of people. Asylum design enforced gender divisions and communal divisions (see Figure IV[106] where the plan separates the male and female sleeping areas and medical facilities and Hindu and Muslim sleeping areas and kitchens). The asylums were fostered environments where those deemed insane by the British could learn the roles the British wanted all Indians to play. The asylum's population was to be productive and ordered, divided into neat religious communities and operating in a gendered division of labour where the men

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[103] *Asylums in the Punjab for the Year 1874*, p2.
[104] *Asylums in Bengal for the Year 1862*, p28.
[105] *Asylums in the Bombay Presidency for the Year 1873-4*, p8.
[106] Attachment in 'Reports on the Asylums for European and Native Insane Patients at Bhowanipore and Dullunda for 1856 and 1857', in *Selections from the Records of the Government of Bengal* no.XXVIII.

worked at cultivation and the skills necessary for village self-sufficiency and the women tended to the domestic requirements of the men. These British fantasies, of what India was and what it ought to be, were built into the asylum treatment regime.

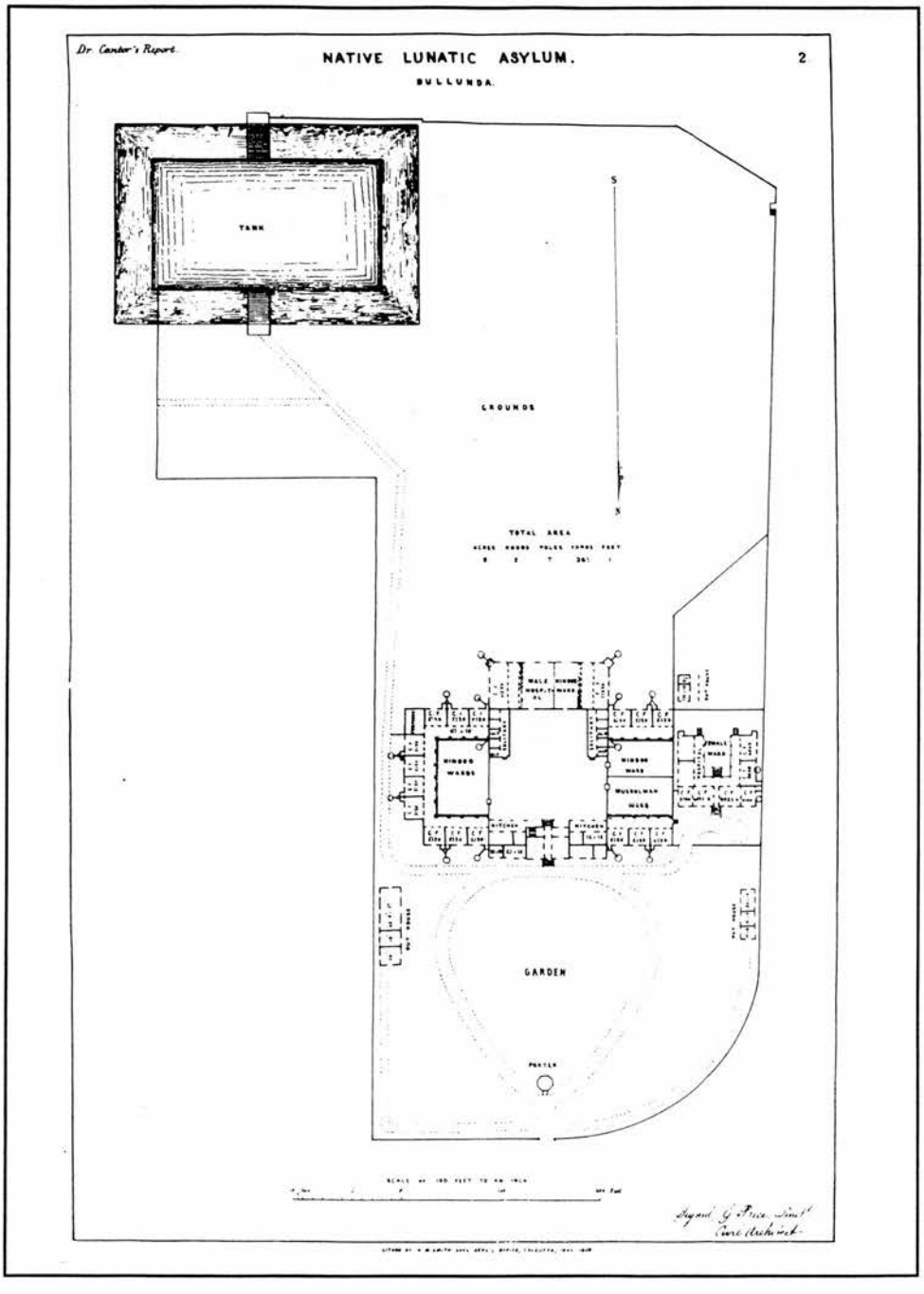

Figure IV. The Dullunda Asylum 1858.

This is not to say that the reform of those Indians in the asylums was the only function of the treatment regimes in the asylum. Some superintendents had other ambitions for their schemes:

> Garden labour, soorrkee making, gunny weaving, twine spinning and stone breaking have all their special uses and are indispensable... but without interfering materially with the progress of these, the labor of those patients who can exercise skill and judgement may, with advantage be diverted into more productive channels. With this object I propose to purchase, as the funds admit, some screw oil presses to be accomodated in the shed... once obtained and in full work there is every reason to believe that they will contribute largely towards making the Institution self-supporting.[107]

This idea that the labour of the inmates should be remunerative and contribute towards the cost of running the asylum was formalised in the tables which had to be returned with the annual reports, so that the superintendents included comments in their narratives like the following:

> Statement No. 10- This statement shows the profits of the labour of the lunatics which amount to Rs. 781-9-4 for the year. As soon as I came here I introduced the manufacture of bon mooj matting in the Asylum, and during the six months the lunatics have worked at it they have made by this alone a clear profit of Rs. 220-3-3.[108]

Indeed, if not engaged in industrial tasks the potential of the asylum population as a source of cheap labour was quickly realised. The superintendent at the asylum in Colaba recounted how "a shed for the fire engine was found to be much wanted and an estimate for its erection was procured from the Executive Engineer amounting to about Rs.400. This was thought too much and the Deputy Surgeon-General suggested that the shed should be erected by the lunatics. The materials were therefore purchased at a cost of Rs.59-5-9 and the work commenced; and when it was finished the shed was valued by the Executive Engineer at Rs.149".[109]

In fact, the systems of labour may well have had other objectives still, such as sedation and control, as hinted at by the superintendent at Bareilly:

> I find that when the insanes are kept unemployed all day they become fretful and troublesome, and pass restless and noisy nights; but if their minds and bodies are occupied during the day, be the labor ever so slight, they appear to enjoy better health, and generally sleep soundly at night.[110]

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[107] *Asylums in Bengal for the Year 1862*, p14.
[108] *Asylums at Bareilly and Benares for the Year 1867*, p57.
[109] *Asylums in the Bombay Presidency for the Year 1873-4*, p6.
[110] *Asylums at Bareilly and Benares for the Year 1867*, pp57-58.

The systems of labour in the asylums also had their pragmatic side then in generating income for the asylums to offset the cost to the Government of India of maintaining the institutions or acting to quieten the patients through fatigue.

CONCLUSION.

There were simpler ways of organizing a place of detention for local psychotics and idiots. Studies in Islamic societies in the Middle East and North Africa have shown how in the medieval period the only institutional response to those deemed dangerously insane was to abandon them to pauper hospitals where 'care' was more the object than 'cure' and they were controlled through restraint and beatings.[111] Similarly, in the eighteenth century in Britain "madmen were chained, whipped, menaced and half-starved in asylums"[112] which acted simply as places of detention.

Yet the British in India did not opt for the model of simple receptacle for the disturbed or actively disordered, as Shridhar Sharma has suggested, and instead devised programmes of physical treatment and 'moral management'. Some physical treatment was a necessity when many of the admissions would have been like that of Ram Deen who "appears a harmless maniac but is in a fearfully debilitated half-starved state".[113] Some work for the inmates could also be understood where the medical officer in charge was determined to see that "the charge of this pauper Asylum to the State be reduced to the lowest possible limit".[114] Yet the range and complexity of the interventions planned by the medical officers is difficult to explain in such mono-causal terms, especially when there is an awareness that the British in charge of the asylums nursed fantasies and ambitions of reforming India and Indians to suit their colonial projects.

It is these fantasies of reform which explain the complexity and extent of the treatment regimes in the asylum. That 'recovery' was related to the ability to labour explains the attention to tending to the body to make it fit, strong and ordered. It also explains the process of first cowing and then transforming the Indian's mind, where kindness, work and rewards were aimed at producing in the ordered Indian a desire to be productive of his own accord. The satisfaction of Dr. Payne at the Dullunda asylum in

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[111]M.Dols (edited by D.Immisch), *Majnun: the madman in medieval Islamic society*, (Clarendon Oxford 1992), pp112-132.
[112]A.Scull, *Social Order/Mental Disorder*, p51.
[113]Case Book II, patient no.203, admitted 22 July 1865.
[114]*Asylums in Bengal for the Year 1862*, p13.

stressing that "I have seen, and do daily see hopeless idiots rendered useful by application to such work",[115] is the satisfaction of a man who is witnessing his regime producing the desired effect: the 'useful', that is productive, member of society.

Indeed the details of the asylum regime, the dividing of the patients by gender, race and religion shows that the asylum regime was intended to do more than fulfil the fantasy of providing useful or productive members of society. The type of work encouraged by the medical officers was intended to create types who would populate the society that the British imagined or wanted India to be, pastoral, patriarchal, and fissured along religious and racial lines.

The coloniser's fantasy of reforming the Indian was examined in Chapter I where the case note was explored as a narrative of colonial ambitions to create the civilized and reformed Indian. Arjun Appadurai provides a summary of this fantasy:

> The project of reform ... involved cleaning up the sleazy, flabby, frail, feminine, obsequious bodies of natives into clean, virile, muscular, moral, and loyal bodies that could be moved into the subjectivities proper to colonialism.[116]

The asylum regime was one of the few sites where the British had access to a population of a manageable enough size to live out the fantasy of reforming the Indian.[117] The intention was to create individuals who disciplined themselves by finding work a pleasure and to this end the medical officers emphasised that "it is my endeavour to make the treatment as individual as possible; and the peculiar idiosyncrasies of the various patients are separately considered, and their wants attended to accordingly".[118] The asylum regime may have attempted to create these self-policing individuals but it also created an environment in which the inmates could re-learn the place that the British imagined that they should occupy in Indian society. Indeed it would appear that the asylum was not a unique place in the colonial system for experimenting with, or acting out the fantasy of, reworking the Indian. Gautam

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[115] *Asylums in Bengal for the Year 1862*, p15.

[116] A.Appadurai, 'Number in the Colonial Imagination', in C.A.Breckenridge and Peter van der Veer (eds.), *Orientalism and the Postcolonial Predicament: Perspectives on South Asia* (University of Pennsylvania Press 1993), p335.

[117] G.Chatterjee argues in *Child Criminals and the Raj: reformation in British jails*, (Akshaya New Delhi 1995) that the reformatory for juvenile delinquents was a place where the British had access to a captive population of Indians and was a place where they attempted to remould the psychology of their subjects. See also L.Mathur, *Kala Pani: history of Andaman and Nicobar Islands with a study of India's Freedom Struggle*, (Eastern Books Delhi 1985), who finds that in the British penal colonies, "one of the main objectives of sending a convict to the penal settlement of Andamans was to provide opportunities to a convict to reform himself", p64.

[118] *Report of the Lunatic Asylums at Bareilly and Benares for the Year 1867*, p59.

Chatterjee has argued in the case of the institution for juvenile offenders that it also "provided an opportunity to intervene and restructure juvenile minds".[119]

A study of treatment regimes in British India in this period then is useful in assessing both the Foucauldian account of the place of asylums in the modernist project and Vaughan's conclusions about the place of psychiatry and medical power in the colonial encounter. It would plainly be nonsensical to see the asylum in British India as Foucauldians see it in Europe:

> A mechanized, regulated, and impersonal social system requires a high degree of conformity, and all the major institutions reflected the effort to render individuals obedient and productive with a minimum of violence and expense. Soldiers, children, workers, patients, and criminals were all subjected to a disciplinary system that attempted to regulate their bodies and souls, and their time and activities. The demographic explosion had created new masses to be divided into groups, subdivided into ranks, assigned fixed spaces, held to a strict timetable, trained to perform according to a precise regimen, supervised, judged, examined and classified in the institutional records as cases. The process of hierarchical observation, normalizing judgement, and constant examination controlled the education of children, the training of soldiers and workers, and the care of patients.[120]

The asylum in British India was not part of a 'carceral archipelago', the Indian population in this period was not typically in a school, factory, reformatory or hospital and was not therefore being subjected to the society-wide process, described by Major-Poetzl above, in which individuals were the level at which power operated to produce the obedient and the efficient. Indeed certain authors have argued that even when Indians were incarcerated in an institution considered characteristic of modern government then power did not operate as it did in Europe, David Arnold concluding that in the jails of British India in the nineteenth century, "the colonial authorities ... abandoned any pretence at individualizing or reforming prisoners".[121]

To this extent it is possible to concur with Megan Vaughan's conclusion that "colonial power cannot be the power which Foucault is describing".[122] Yet this study of the asylum regime has suggested that in certain parts of the colonial system there were regimes operating in which power was seeking to act on the individual and where the intention was not just to detain or to punish but to produce, that is to produce obedient, productive and self-regulating people. As such then, psychiatry in this

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[119]G.Chatterjee, *Child Criminals and the Raj*, p188.
[120]P.Major-Poetzl, *Michel Foucault's Archaeology of Western Culture: toward a new science of history*, (University of North Carolina Press 1983), p204.
[121]D.Arnold, *The Colonial Prison*, p187.
[122]M.Vaughan, *Curing their Ills*, p11.

period in colonial India seems different from the psychiatry of colonial Africa described by Megan Vaughan earlier in this chapter, as it did not largely concern itself with establishing the 'Other'-ness of the colonial subject. Rather it accepted the Indian as the 'Other' and set about re-forming it, 'producing' it, as the useful and self-policing individual. Megan Vaughan may well be correct in observing that "colonial states were hardly 'modern states' for much of their short existence".[123] However, in the treatment regimes of the asylums of British India in this period it is possible to see how they dreamt of being so and forgot that they were not.

[123]M.Vaughan, *Curing their Ills*, p10.

CHAPTER V.

Indians into Asylums: local communities and the medical institution.

CHAPTER V. INDIANS INTO ASYLUMS: LOCAL COMMUNITIES AND THE MEDICAL INSTITUTION.

Studies of colonial medical projects in India tend to show that the initial response of the indigenous communities was to reject Western medical interventions. Mark Harrison concluded for example that "the testimonies of both Europeans and Indians indicate that hostility or indifference towards sanitary regulations persisted in most areas of India",[1] and David Arnold's account of smallpox vaccination projects emphasises the "Indian antipathy to vaccination and the coercive, unheeding system of colonialism it was taken to represent".[2] Both however also show how it was elite Indians whose acceptance of parts of Western medicine ensured that the colonial state was able to negotiate the penetration of their medical projects into Indian society. As such what is left is an image of non-elite Indians resorting to 'riot and resistance' when confronted by Western medicine or else those who did engage with it amongst non-elite groups were characteristically the "mendicant class and prostitutes",[3] who were hardly representative of local Indian communities as a whole.

These emphases in looking at the responses of Indians to Western medicine are largely the result of the sorts of projects that have been examined. Large-scale interventions like public health projects, vaccination programmes and the measures taken in the face of epidemics involved the sudden reorganisation of large populations using coercive measures so it comes as no surprise that reactions to these were often dramatic. However these large-scale interventions were not necessarily typical of colonial medicine as both Arnold and Harrison seem to acknowledge in the few pages that they devote to dispensaries in India. By 1860 Arnold reckons that almost 300 000 people attended the 46 dispensaries in the Madras Presidency[4] and Harrison shows that in 1867 a similar number visited the 61 institutions of Bengal.[5] Yet the reactions and responses of the Indian community to these small-scale and low-priority but nevertheless well attended and much used sites on the interface of colonial medicine and Indian society are summarised in a few lines by both authors. Harrison limits himself to showing how the dispensaries failed to attract female members of the local community and Arnold decides that the factors which lay behind low-status Indians

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[1]M.Harrison, *Public Health in British India: Anglo-Indian preventive medicine 1859-1914*, (Cambridge University Press 1994), p232.
[2]D.Arnold, 'Smallpox and colonial medicine in nineteenth century India', in D.Arnold (ed.), *Imperial Medicine and Indigenous Societies*, (Oxford University Press 1988), p62.
[3]D.Arnold, *Colonizing the Body: state medicine and epidemic disease in nineteenth-century India*, (Oxford University Press 1993), p250.
[4]Ibid., p248.
[5]M.Harrison, *Public Health in British India*, p89.

using the dispensaries in such numbers was either that they lacked the religious and cultural sensitivities of elite Indians or that they "became patients less from choice than from desperation or because the police or their European employers sent them there".[6]

By focusing on the interaction of the local community with the lunatic asylum it will be possible to explore more completely the responses of Indians to the local medical centres set up by the British which would have been for most Indians the first point of contact that they had with Western medicine. Like the dispensary the asylum was only one of the responsibilities of the European Civil Surgeon at that station,[7] it was commonly administered on a day-to-day basis by Indian staff and it was the subject of constant carping by the colonial authorities about its finances and its utility.[8] In other words the interaction of Indians with the low-priority and local colonial medical project will be explored in this chapter.

This interaction will be explored by looking at the most intriguing of the case notes available at the Lucknow lunatic asylum, those of the Indian inmates admitted by themselves, members of their families or by their own communities. In other words here the focus is on the Indians committed by Indians. A further qualification has been made, that Indians sent in by Indians acting in an official capacity, as policemen, doctors or magistrates, are not to be included in the group considered here: the influences on the Indian working in the British system is a separate issue to be dealt with elsewhere.

The case notes are unusual as most of the others can be readily explained in the colonial context. As has been seen, the British interest in order accounts for most of the admissions of non-criminal lunatics made by the authorities, and the inability of their prison system to cope with convicts unwilling to submit to the most basic demands of its disciplinary regime explains most of the criminal lunatics committed. But the question of why Indians should submit members of their own community to such an alien space is not so easily answered.

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[6]D.Arnold, *Colonizing the Body*, p250

[7]The multitude of duties that the Civil Surgeon was required to attend to is discussed further in a focus on the staffing arrangements of the asylums in Chapter VI.

[8]For dispensary finance see Harrison, p88: for asylum finances see the Conclusion.

It should be emphasised that the step of admitting oneself or someone from the family or community into the asylum would not have been a matter of routine for a non-elite Indian in this period simply for the reason that the lunatic asylum would have been such an unfamiliar environment. As Shridhar Sharma says:

> The establishment, segregation of lunatics in mental asylums, and their supervision were entirely of British conception.[9]

India had its own complex and long-established mechanisms for reacting to psychic distress to which the British institution was entirely unrelated. In considering Indian responses to mental disorder, Sudhir Kakar points out that when it comes to mental disorder:

> Like very few other people, Indians have long been involved in constructing explanatory techniques for its alleviation ... there are the traditional physicians-the vaids of the Hindhu Ayurveda and Siddha systems and the hakim of the Islamic unani tradition-many of whom also practice what we today call 'psychological medicine'. In addition there are palmists, horoscope specialists, herbalists, diviners, sorcerers and a variety of shamans, whose therapeutic efforts combine elements from classical Indian astrology, medicine, alchemy and magic, with beliefs and practices from the folk and popular traditions. And then, of course, we have the ubiquitous sadhus, swamis, maharajs, babas, matas and bhagwans, who trace their lineage, in some fashion or other, to the mystical-spiritual traditions of Indian antiquity.[10]

There is no evidence of hospitals on the Western model existing for the insane in India before the British arrived. Places of detention for the psychotic existed in some Muslim societies in the Middle-East,[11] and there may well have been the odd charitable institution in India before the British arrived, such as that founded in the reign of Mohammed Khilji in the fifteenth century which aimed at providing for the poor and the vagrant in India and in which many of those deemed mad locally would have ended up.[12] None of these would have resembled the British asylum though.

This can be seen by comparing the plans of the asylums included in these pages with an account of a healing temple near Bharatpur which catered for those considered to be behaving oddly by their local community. The asylum design emphasises the separating

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[9]S.Sharma, *Mental Hospitals in India*, (Directorate General of Health Services New Delhi 1990), p49.
[10]S.Kakar, *Shamans, Mystics and Doctors: A Psychological Inquiry into India and Its Healing Traditions*, (Oxford University Press 1982), p1.
[11]M.Dols (edited by D.Immisch), *Majnun: the madman in medieval Islamic society*, (Clarendon Oxford 1992).
[12]S.Sharma, *Mental Hospitals in India*, p49.

out of functions, there are separate spaces for sleeping in, for cooking in, for working and walking in and in which treatment would be received for physical illness. Sudhir Kakar includes an account of the temple which directly contrasts with this, as within its confines at any one moment there is a welter of activity, as 'patients', their relatives and the priests eat, sleep, pray, exorcise and have violent attacks all in the same space which they share with local urchins and stray dogs.[13]

This physical contrast reflects a more profound difference in the aims and approaches, indeed in the understanding of mental illness, between the culture from which the lunatic asylum emerged in early modern Western Europe and the cultures in which the local healers and temple practitioners developed in India. In Europe, by the nineteenth century, madness had come to be perceived as having "a hold on Western culture which makes possible all contestation, as well as total contestation".[14] The asylum was a specific response to this cultural perception, it was "a religious domain without religion, a domain of pure morality, of ethical uniformity",[15] to be used as "an instrument of moral uniformity and of social denunciation".[16]

In India, Kakar finds that "the restoration of the lost harmony between the person and his group ... was one of the primary aims of the healing endeavours in the local and folk traditions".[17] To this end it is necessary to "avoid isolating the individual",[18] and so "beliefs about a mad-person's actions do not implicate the individual's self but instead focus on causes external to the individual, often supernatural ones".[19] In Northern India, for example, "*peshi* ritual attempts to transform the patient's belief into a conviction that his bad traits and impulses are not within but without; that they are not his own but belong to the *bhuta*".[20] Therapy is not an individual undertaking but a group practice: "When a mad person is believed to have been possessed by a demon, the whole family, their relatives and neighbours, sometimes the whole village, join together to plan, carry out and pay for the appropriate exorcism ceremony".[21] If a sacred institution is visited for

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[13]S.Kakar, *Shamans, Mystics and Doctors*, pp60-65.
[14]M.Foucault (translated by Richard Howard), *Madness and Civilization: A History of Insanity in the Age of Reason*, (Routledge London 1989), p281.
[15]Ibid.,p257.
[16]Ibid., p259.
[17]S.Kakar, *Shamans, Mystics and Doctors*, p274.
[18]N.Waxler, 'Is Mental Illness Cured in Traditional Societies? A Theoretical Analysis', in *Culture, Medicine and Psychiatry*, Vol I 1977, p240.
[19]Ibid., p240.
[20]S.Kakar, *Shamans, Mystics and Doctors*, p287.
[21]N.Waxler, 'Is Mental Illness Cured in Traditional Societies?', p241.

treatment, the temple rituals will emphasise "the involvement and the integration of the patient's relatives in the healing process".[22]

These traditions contrast with the aims and processes of the lunatic asylum. Isolated from society behind the walls of the institution "the insane were 'treated' by being forced to recognize and accept responsibility for their guilt ... the inmates were not merely observed and judged by others but were required to examine and judge themselves".[23] The asylum was not "a free realm of observation, diagnosis, and therapeutics; it is a juridical space where one is accused, judged and condemned, and from which one is never released except by the version of this trial in psychological depth-that is, by remorse".[24] The lunatic asylum sought to impose a *moral* system on the patient through isolation and inducing guilt within the individual. The Indian approaches emphasised the need to reintegrate the individual with his/her *social* system, and as such avoided isolation of the individual and advocated group involvement in treatment. It is difficult to contest the view that "in India, mental asylums were entirely a British conception".[25]

Yet for all this there are case notes available at the Lucknow lunatic asylum which suggest that Indians were admitting themselves or members of their families and communities to this alien space. These cases will be looked at in three groups, those who decided to admit themselves to the asylum, those who admitted others but reclaimed them from the institution and those who abandoned members of their families to the institution.

Self Admissions.

Bhagooie. Dementia. Mussulman. Beggar. 45. 19 March 1861

Mar 1861
This woman had long been a vagrant beggar in Lucknow and was in the habit of sleeping under the archways in the Cheenie Bazaar. She was almost destitute of clothing, dirty and lousy- She came and herself begged for admission into the asylum-she is evidently a person of weak intellect- is also suffering from venereal disease.

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[22]S.Kakar, *Shamans, Mystics and Doctors,* p83.
[23]P.Major-Poetzl, *Michel Foucault's Archaeology of Western Culture-Toward a New Science of History*, (University of North Carolina Press 1983), p132.
[24]M.Foucault, *Madness and Civilization,* p269.
[25]S.Sharma, *Mental Hospitals in India*, p49.

1862
This woman improved very much in general health and habits by attention and kind treatment. Altho' evidently of weak intellect, she had a fair understanding of her position and on her husband being discovered, showed an anxiety to leave the Asylum and join him.

She was discharged, cured. Sept. 21/1862.[26]

Women in north India occupy a very precarious position in society, as Roger and Patricia Jeffery have stated after their study of the contemporary situation: "A key feature of the position of all women remains their dependence on men".[27] They go on to show how in modern north India the woman is more likely to have left her natal village and to live her life in her affinal village after marriage. Her position and security there are derived from the presence of her husband.

Now, if this was the case in the 1860s it is a useful context for exploring Bhagooie's case. The story strongly suggests that she was abandoned by her spouse at a time when she would no longer have been valued as a source of productive labour in her village because she had grown old. Consequently her position in the village would have become intolerable and she would have found herself separated out from the community or indeed may have taken the initiative herself and decided to go and find her absent spouse. Whichever was the case her fate as a single woman without access to a community was to take to begging, a harsh and distressing lifestyle which caused her to become ill. Realising that she is ill and that her position is worsening she seeks shelter in the nearby British institution, which happens to be the lunatic asylum. The doctor admits her, seeing her ill through neglect and diagnosing the jumbled thoughts of one who has suffered desertion, illness and starvation as 'weak intellect'.[28]

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[26]Case Book IA, patient no.92, admitted 22nd March 1861.

[27]R.Jeffery and P.M.Jeffery, 'A Woman Belongs to Her Husband', in Alice Clark (ed.), *Gender and Political Economy: Explorations of South Asian Systems,* (Oxford University Press 1994), p94.

[28]Bhagooie would not necessarily have to have acted oddly to have gained admission. 'Weak intellect' as a diagnosis seems to describe behaviour involving reluctance to speak or answer questions. Dullee (Case Book IA, patient no.9, admitted 4 April 1860) is described as "of weak intellect", and the only symptom noted is, "very quiet, indeed never opens his mouth". For Khooda Buksh (Case Book IA, patient no.10, admitted 24 April 1860) the conclusion is that "his intellect seems weak but he does not appear to labour under any delusion". The behaviour noted on admission on which this is based is that he "is very quiet and well-conducted". It would seem then that had Bhagooie behaved as would be expected on her meeting with the European doctor, that is if she had displayed the reticence that would be natural for an Indian woman being addressed by a white, male official, she could have been diagnosed as of 'weak intellect', especially as the doctor had noted her dishevelled state on the basis of which he would have decided that her behaviour fitted into the familiar category of madness brought on by want. This was a link explicitly made in other cases, such as Madarow (Case Book II, patient no.167, admitted 12 April 1865). The opinion is that "this girl appears to have gone mad from starvation and bad treatment".

Once in this refuge, where she is fed and goes unmolested, she quickly regains her health and her perspective. When the husband is found by the British authorities whose policy it was to try and find the relatives of all harmless, wandering lunatics, she is eager to return to her 'normal' existence which she had never wished to desert in the first place. In her case then, the asylum appears to be a place she has used to recover from a crisis in her life and she has taken advantage of it to regain her strength and shelter from the harshness of an unexpected period as a vagrant.

Bhugwan Deen. Mania. aheer. beggar. 40. 20 April '61

1861 April
This man is a beggar by profession and for some time has lived in the Ameenabad Bazaar. He of his own accord begged admission into the Asylum- He appears perfectly quiet and inoffensive- has a very vacant expression and countenance- never speaks unless spoken to- fancies that he is sovereign of the world- Doorgah ke Malik- and has large armies, palaces equipages etc. at his command.

1863.
This poor creature continued very happy and contented in the Asylum, generally enjoying very good health- During the rains of 1863 he was several times affected with Diarrhoea which as often got well- During the cold weather he became dropsical, the Diarrhoea returned and he gradually sank and died 17th Dec 1863.[29]

Bhugwan Deen is another of the self-admissions who appears to have built the facilities of the British asylum into his survival strategies. He is advancing in years and has been on the streets in poverty long enough to become known as 'a beggar by profession'. Naturally then, the regular meals and ordered existence within the British institution would have appeared an appealing prospect. In order to gain admission he shams a little with a tale about imagining himself a member of royalty and having got inside he gives no trouble to anyone, content to wile away his days looking forward to his sleep and his food. There is every reason to suspect he was shamming as there is no mention of his delusion again on the case note, which is unusual as other case notes reveal that the British medical officers keenly recorded the progress of their patient's delusions as and when they manifested themselves,[30] and indeed if he really

[29]Case Book IA, patient no.97, admitted 20 April 1861.

[30]The case note for Zahoorun (Case Book IA, patient no.4, admitted 16 December 1859) is a good example of this. On admission her "many hallucinations, such as the existence of a large snake in her belly", are remarked upon. Each entry thereafter makes reference to her beliefs. In December, three months after admission, a note is made that "she fancies that she is possessed of great wealth and is the proprietress of hundreds of villages". Three months later the entry observes that there is "no alteration in her symptoms- the same fanciful notions about the snake + her imaginary wealth". The next note adds that she thinks "she is utterly starved in the asylum and is fed with dead men's flesh", and the final entry is that "this woman continues to believe that she is fed with abominable filth. The snake left her 1000 years ago, that is to say when she was 500 years old". The fascination with the details of delusions is evident elsewhere. Whenever there is a lengthy note on Aluf (Case Book IV, patient no.187, admitted 29 April 1870), his peculiarities are remarked upon. In 1870,

did believe he was 'sovereign of the world' it seems odd that he would choose somewhere as modest as the lunatic asylum as his residence. There is also evidence from another group of patients in the asylum that shamming to gain entry was an option when a period there was deemed desirable. This group is the prisoners admitted from the Jail to the asylum.

For a prisoner awaiting trial, feigned madness was a way of establishing a defence. If it was suspected that you were mad at the time the crime was committed, you would be acquitted once sane enough to stand trial. It was in the interests of the accused to be sent to the asylum on, or soon after, the arrest to increase the chances that the insanity observed then would be linked to the circumstances of the crime. For the prisoner already tried and serving a long sentence, the asylum was attractive as it did not force its inmates to labour, whereas the prisons did, and small indulgences like tobacco or sweetmeats were allowed the patients while such luxuries were denied the prisoners. It seems that some did try to pretend to be insane for these reasons.

Mongloo. amentia. 30. Hindoo. cultivator. 30 Augt. 64. Prisoner

1862 A Pasee- accused of Dacoitee + sent in for observation by Dr. Lane, Offg D.C. as he feigned madness- Several of his gang have already been transported or sentenced. I could not detect any real insanity. He was very much on his guard not to betray himself, so I sent him back to the D.C. for trial.

Discharged 6th September 1864.[31]

Not that all of the prisoners who tried to get themselves a place in the asylum rather than the prison failed. An interesting case occurred in the Central Provinces:

> Only one man (Dina whose case was referred to in para 3 of last year's report) was re-admitted into the Nagpur Asylum. The Superintendent, Doctor Brake, thus reports about him:-
>
> This man was very intractable at the Nagpur central Jail, dirty in his habits, full of antics, refusing to work and reported to be sleepless at nights, but no sooner was he received back into the asylum, than all symptoms of insanity disappeared; the man slept, ate and worked well and was frequently employed in supervising others, always assisting them in their several

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"hallucinations of a religious nature" are noted, in 1874, his remark, "my eyes are burst from looking at the sun", and his statement that "his penis is as big as his arm", are recorded and in 1878 the fact that he "presents himself with a white flower stuck in each nostril", is put down. The delusions of Khooshal (Case Book II, patient no.115, admitted 28 June 1864) are noted in each lengthy report on him after they come to light in 1868. "Seems to have exalted ideas about his possessions. States that he has some lacs of horses and velvet harnesses", is followed up later with "Is full of illusions as to immense wealth and possessions", and on other occasions his comments that "I have 9 lacs of elephants" and "Formerly I used to eat gold and silver", are recorded.

[31]Case Book II, patient no.130, admitted 30 August 1864.

> occupations. He remained till November 13th the day preceding the expiry of his sentence when he was made over to the Jail authorities for release as quite sane.[32]

It can be inferred that his first period in the asylum had agreed with Dina as much as his second stay did otherwise the British would not have returned him to the prison in the belief that he was sane. However, having had a chance to compare the two regimes Dina seems to have quickly decided that the asylum was preferable. He therefore seems to have set out to behave in ways he felt would get him transferred from the prison back into the asylum, behaviour he did not particularly enjoy putting on as he quickly abandons it once back in his preferred institution. His strategy to get through his sentence in as comfortable a manner as possible seems to have been a complete success as he manages to see out the remaining months of his time in the asylum rather than the prison.

Of course it is impossible to say for sure that those who appear to be feigning madness or were accused of having done so at the time were actually doing so. It must be said though that as either vagrants or prisoners life on the streets or in the jail could at some point have involved contact with or witnessing someone who was subsequently institutionalised as a lunatic, in other words there would have been opportunities for the beggar or the convict to observe what types of behaviour guaranteed admission into the asylum. If the need to gain admission arose, behaviour which would be perceived as insane could then have been simulated.

Bhugwan Deen and Bhagooie, and indeed the prisoners who feigned madness and like the beggars are examples of self-admission, seem to be using the asylum as a sort of refuge. Simply, they have incorporated the British institution into their strategies for survival. The same seems to be true of the other patients on whose case notes self-admission is explicitly noted such as Boata Shaw,[33] who "applied himself for admission" and whiled away his days working in the garden until he died seven years later.

Indeed the British themselves fretted that their medical institutions were being used by Indians in such ways. In an article in 1877 printed in the *Indian Medical Gazette*, entitled 'Poor-Houses or Hospitals?' the editor thundered:

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[32]*Report on the Lunatic Asylums in the Central Provinces for the Year 1879*, p1.
[33]Case Book IA, patient no.193, admitted 5 May 1862.

> It is not fair that dispensaries, and the medical profession at large, should have this duty of a Parish relief wholly put upon them.

He went on to describe a figure considered familiar at the dispensary by medical officers, a man

> who is notoriously a professional beggar. Times are hard with him, and he has determined that it will be comfortable to pass the winter as a house patient. He accordingly arranges to be picked up by the police and carried thither as a 'destitute'.[34]

All this then is rather more than the 'desperation' that David Arnold believed motivated Indians to use the local British medical facilities in his account of dispensaries mentioned above. Certain members of the local community were actively incorporating the asylum into their survival strategies, colonizing the relatively sheltered space made available by the British to suit their needs and agendas rather than turning to it blindly in a moment of panic. It should also be pointed out that there is no evidence that these patients were admitting themselves out of a desire for access to Western methods of therapy for mental health, or under the conviction that they were mentally ill and needed treatment: they were admitting themselves to make their lives safer and more comfortable.

Family and Community admissions.

As already stated the Indians admitted by their families or communities can roughly be divided in terms of their fate as there were those who were subjected to a short period in the institution by those around them while some were abandoned to it altogether. Those who were reclaimed will be considered first.

> Mooloowa. Mania ch. 22. Hindoo. Labour. 28 Sept/65
>
> 29th Septr 1865
> Sent to the asylum at the request of his Uncle Seeun Village Samgunpoor as they had no means of keeping him under control- is very violent and abusive.
>
> 1st Feby 1866
> As bad as ever.
>
> 7th May 1866
> Made over to his mother by order of the Visiting Committee.[35]

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[34] *Indian Medical Gazette*, Vol.XII, March 1 1877, p76.
[35] Case Book II, patient no.222, admitted 28 September 1865.

In Mooloowa's example, it seems that the 'control' sought by his family is not simply physical restraint. Various accounts show how Indians devised ways of restricting the physical freedom of those within their community without involving the British authorities. The Lucknow case notes have a couple of examples such as Deerumeere who was "found wandering about the district with irons on his legs, put on by his relatives to keep him fast",[36] or Nundia who appears to have "escaped from his home in chains where he had evidently confined for years".[37] Other devices are mentioned in other sources. A witness in a murder case described the proceedings once the member of a neighbouring family started having fits of violent behaviour. "Zalim was then put into the stocks by his brother. I never saw him out of them. He had his food whilst in the stocks, and answered the calls of nature in the same place".[38] The District Superintendent of Police for the area described the stocks. "They consisted of a piece of wood roughly fashioned by the relations themselves and did not belong to any outpost or station. The latter stocks have been entirely done away with for some time back".[39]

In Mooloowa's case then, physical restraint was not the object of the committal. He was being punished. The idea of committing family members as a means of disciplining them is familiar from studies done of the place of the asylum in other societies.

> A young slater's assistant, apparently living with his parents, was committed for threatening to cut his father's throat, having a razor, and 'delusions'. On admission he smelled of whiskey, seemed to be recovering from a drunken bout but was quite rational and coherent. A few days before, he said, he tried to separate his father and mother in a family quarrel; both were drunk. They subsequently swore informations against him, and in his words 'had him sent here to teach him a lesson'. A week after admission his father came to take him out on bail; questioned by the doctor, he corroborated the son's story. He 'moreover assured me that at no time did he consider his son insane, but that he thought it would do him (the son) good to get a few days here'.[40]

Using such archival examples, Mark Finnane constructs the argument that in Ireland, during the same period as is being discussed here,

> the use of the asylum, or the threat of it, as an instrument of control in the family could be quite blatant.[41]

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[36]Case Book IA, patient no.128, admitted 24th August 1861.
[37]Case Book II, patient no.158, admitted 28th February 1865: case note transcribed as on original.
[38]Deposition of Seetul Sonar in NWP Judicial (Criminal) March 1864, 14A.
[39]Super.Police Goruckpore to I.G.Police Benares 22 October 1863 in NWP Judicial (Criminal) March 1864, 26A.
[40]M.Finnane, *Insanity and the Insane in post-Famine Ireland*, (Croom Helm London 1981), p163.
[41]Ibid.

This conclusion would seem applicable to the example of Radha, aged 25, who appears in the Lucknow case notes.

Radha. Mania. 25. Brahmin. Cult. 1 Feby/65

1st Feby 1865
Sent in by City Magistrate of Lucknow.

22nd April 1865
This man was brought by his brother for confinement, he was found very difficult to manage at home- constantly running about his village abusing the women. No improvement since admission

Septr 1865
Made over to his friends at their request.[42]

Obviously embarrassing his relatives with his behaviour towards the womenfolk where he lived, and evidently refusing to obey his family's wish that he refrain from such behaviour, they, or certain of them, had decided to punish him by severing him from his community and admitting him into the strange institution. It was only meant to be a punishment though as he was not abandoned, being collected from the asylum again a few months later.

The step of committing to an asylum was not done simply to have the person restrained then, the Indian community could do this without involving the British. To remove the errant member from his kin-group into an unfamiliar institution where he was exposed to an alien regime was indeed a punishment, it denied the person access to the group for whom his behaviour was meant to have significance and isolated him from the people his actions were meant to influence. For the family, or the member of the family who had taken the responsibility for the step, it was a way of asserting the authority of the status quo to which the disruptive behaviour had been a challenge.

It is interesting to note that most of the examples of Indians admitted by Indians for a short term are junior members of the family being committed by senior ones. Mooloowa quoted above is 22 years old and admitted by his uncle. Shew Dial is 28 years old and "brought to the Asylum by his father who is a chowkidar in Lucknow".[43] Kandhya is only 20 and was "said to have attempted to fire his village and to have been so violent as to be uncontrollable by his brother".[44] Clearly then,

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[42]Case Book II, patient no.149, admitted 1 February 1865.
[43]Case Book IA, patient no.202, admitted 10 June 1862.
[44]Case Book II, patient no.70, admitted 8 December 1863.

those within the family with power were exercising it to discipline those over whom their authority was held. However this was a punitive rather than a purgative exercise, the family or community was asserting its authority over a member who was considered to be transgressing its correct functioning but who as a young man was valuable enough as a source of labour not to abandon.

If committal could be a disciplinary procedure, the admission of young women for 'puerperal mania' is intriguing. This was the name given in the nineteenth century to erratic behaviour in new mothers in the immediate post-partum period. In Victorian Britain, motherhood was constructed as the "pure and almost sacred state"[45] of femininity, and so women who behaved in ways viewed as unfeminine in the post-partum period, be it flaunting their sexuality, threatening violence or expressing extreme emotion, were deemed to be acting in a deviant manner and were treated as lunatics.

In India child birth is similarly given cultural meaning, although the text varies somewhat from the British example. Studies of contemporary India show that "a new mother is unclean for five weeks. For all that time no one should eat food which she has cooked".[46] She is considered embarrassing, "her physiological processes are shameful, distasteful and striking evidence of her sexuality".[47] It seems that the culture chastises her for her behaviour in childbirth by denying her access to her natal family for a specified period after the birth.

If this was the case in the 1860s then there appears to be an interesting convergence of cultures between the British medical officers at the asylum and the Indian men of the local communities. These groups would have considered female behaviour in the period immediately after child birth potentially problematic. As such cases like that of Mosst. Goolaba are especially intriguing.

Mosst. Goolaba. Puerperal Mania. 25. Hindoo. Labour. 15th June 1870
Certified by the Magistrate. Talks nonsense.

15th June 1870
Sent in by the Magistrate of Lucknow it is evidently a case of puerperal mania the woman has become mad after the birth of each child.

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[45]E.Showalter, *The Female Malady: women, madness and English culture, 1830-1980*, (Virago London 1987), 58.
[46]A village midwife quoted in, R.Jeffery and P.Jeffery, 'A Woman Belongs to Her Husband', p99.
[47]Ibid., p100.

11th July
Admitted for treatment by order of the Committee.

5th Decr 1870
Discharged much improved and made over to her mother.[48]

There is very strong evidence here that her family were involved in her admission. It seems unlikely that she has been admitted to the asylum before as a previous admission is usually traced and remarked upon in the case notes.[49] The information that she has on other occasions behaved in a similar manner to that which she was exhibiting on admission is likely therefore to have come from someone who the superintendent would accept such information from, that is a member of her family who he would find credible as a witness to her other births. That such a family exists for her is proven by the fact that her mother comes to collect her. She is not noted as violent, which other records suggest would have been the case if she had been,[50] so it seems unlikely that she has been noticed by the police. If her only misdemeanour is to express herself in unfamiliar verbal formulations, that is to talk nonsense, it is probable that the only people in a position to notice and inform the medical officer writing the case note would have been her family as it would not have been likely, especially in the post-partum period, that anyone else would have had access to her.

The only clue that the case note offers as to why she has been considered insane, that she 'talks nonsense', could be less a symptom of illness and more the key to explaining her admission. A refusal to talk in the prescribed manner, which is likely to have entailed, or been interpreted as entailing, a lack of respect for senior members of her family has been linked with the local understanding of childbirth as a time when the female is most in defiance of the norms established for her by the patriarchal culture and it has been decided that hers is a challenge to the established order of the family. She has therefore been banished from that unit until such time as she again recognises the authority of that order. She is not abandoned though as she is valuable, being young enough to be productive and having proven to be reproductive. So she is

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[48]Case Book IV, patient no.202, admitted 15 June 1870.

[49]For example Hanooman's notes (Case Book IA, patient no.222, admitted 20 August 1862) record that he "had previously been an inmate in the Asylum and was discharged in July 1861". The tracing of previous admissions seems to have been so efficient that those treated in the Jail Hospital for insanity before the establishment of the Asylum have it noted when admitted into the Asylum. Kurreem Buy (Case Book IA, patient no.40, admitted 20 July 1860) was "once in the Asylum in the Jail".

[50]For example another puerperal maniac is admitted 3 months after Mosst. Goolaba. Mosst.Rhuman (Case Book IV, patient no.220, admitted 15 September 1870) was "Certified by the Magistrate Violent". She was handed over to her husband 8 months later.

taken back when 'Much improved', that is, once more quiet and respectful, and after a lengthy enough time for her to have become dissociated from her sexualised period.

There are then reasons to believe that the involvement of families in the admission of junior members of the family to the alien space that was the British asylum seems in certain cases to have been a disciplinary measure. There is no evidence that these families and communities were admitting their members out of a desire for access to Western methods of treatment for mental health, or in the belief that they were mentally ill and were in need of therapy. There is evidence that those admitted by their families or community members had been exhibiting behaviour which would have embarrassed their families or been interpreted as disobedience or improper behaviour. No doubt after a number of attempts to get the errant member to toe the line the unfamiliar environment of the British institution and estrangement from the family were decided upon as a means of silencing the challenge of the junior member to the established order of the family. The member was banished but not abandoned as the youngster was valuable to the family, at the very least as a source of productive and/or reproductive labour.

Permanent admissions.

Bhugia. Mania. 40. caste. Service. 15th Jany/63

1863. Sent in by City Magistrate at the request of her husband who is a sweeper at the Martinière College She has been insane for years but has recently become wholly unmanageable She roams about picking up all sorts of filth and rubs herself over with excrement- at home she is entirely intolerable.

June 1864. This woman is much the same, I see no reasonable hope of her ultimate recovery.

Jany 1870.. No better is likely to remain and die an inmate of the Asylum.[51]

The idea that admission to the asylum is being used by the Indian community as a disciplinary measure is difficult to sustain for those cases where the patient is left to die in the institution. Another explanation is needed for those abandoned.

The work of Nancy Waxler, who has studied mental illness in modern day Sri Lanka, contains a number of insights which offer an explanation as to why Indians were abandoning members of their families to the alien institution. She concludes that

[51]Case Book II, patient no.3, admitted 15 January 1863.

"deviance and the sanctions society uses serve integrating functions in small societies",[52] going on to state that

> the peasant family that provides treatment for its mentally ill member is, at the same time, effectively strengthening its own family structure by creating obligations between the patient and family, obligations that must be fulfilled later... In this sense the family group is further integrated by the fact of the child's illness.[53]

While a mental illness incident in the family can actually be the occasion of the group bonding itself as a unit, long-term disorder tended to have other consequences:

> Both beliefs and practices press the mentally ill person toward return to normality ... In Sri Lanka for example the costs of remaining sick for long periods after appropriate treatment are much greater than the costs of return to normality; those who do remain chronically ill are threatened not only with barren lives, but also, ultimately, by lack of food and shelter and, most significant, loss of family ties.[54]

While it would obviously be very difficult to compare modern Sri Lankan villages with mid-nineteenth century North Indian ones, the model she derives from her study seems useful in explaining the patients abandoned to the asylum in the Lucknow case-notes. The case notes from Lucknow of those who are abandoned to the asylum seem to show that they were suffering from long-term disorders. This was the case with Bhugia who was committed by her husband when her behaviour worsened after years of problems and also appears to be the case with Bhoondoo:

> Bhoondoo. Dementia. 35. caste. service. 16 June/63
>
> Sent in from Cantonment Joint Magistrate. His mother states he has been getting worse for the last two years, and is now unsafe. Cannot be trusted for one moment alone, and is sometimes violent.
>
> 20th August. Died of chronic dysentery.[55]

Using these patients then it is possible to suggest that in North India, as in the Sri Lanka of Waxler's study, those suffering with long-term mental disorders were viewed as a burden to be removed permanently from the family. It must be remembered that the minority of such evictions from the family would have been into the asylum. The majority would have been onto the street, which accounts for the number of wandering lunatics for which the British built the asylum in the first place.

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[52]N.Waxler, 'Is Mental Illness Cured in Traditional Societies?', p239.
[53]Ibid., p243.
[54]Ibid., p248.
[55]Case Book II, patient no.38, admitted 16 June 1863.

It could be then that these are examples of Indians sending their mentally ill into the British asylum. But they are not sent in because the Indians have any faith in the Western modes of therapy. They are being sent in not for treatment but for care, in other words there is no expectation of cure on the part of the families when these patients are consigned to the asylum of the British, rather there is the expectation that the cast off relatives or friends will at least be fed and given a bed, something the family is unwilling to supply any longer.

CONCLUSION.

> Imperialist medicine promotes political control, social inequality and exploitation, but it also contains many contradictions. It promotes new forms of consciousness, social structure and political action.[56]

The lunatic asylum in British India has been demonstrated in previous chapters to be situated squarely in the disciplinary projects of the colonisers, or as James Paul would have it, in the systems which promoted 'political control' and 'exploitation'. His conclusion is useful as it raises the possibilities of contradictory impacts when looking at colonial medicine. Yet it is included here as he seems typical of many historians who when looking at colonialism, and colonial medicine in particular, emphasise the impact of interventions and the significance of the colonial presence. The examples in this chapter have highlighted responses less dramatic but possibly more significant for understanding colonialism and the impact of colonial medicine.

Quite simply, the Indians featured interacting with the asylum were going about their business, the homeless seeking shelter, parents disciplining errant juniors, communities passing on the burden and cost of useless members. In the course of pursuing these mundane and rather unspectacular agendas they were coopting the colonial space, the isolated medical outpost of Empire, into their worlds. There are no new forms of consciousness here, no political control or corresponding reactive political action. Quite simply various members of Indian society were carrying on their day to day lives and making use of whatever local resources, in this case those supplied by the colonial state, were available for them to get on with those lives. Indeed there is little evidence that the local communities realised what sort of an institution the lunatic asylum was let alone decided that they would abandon their own understandings of mental illness and appropriate therapy. Rather, the Indian

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[56]J.Paul, 'Medicine and Imperialism', in J.Ehrenreich (ed.), *The Cultural Crisis of Modern Medicine* (Monthly Review Press New York 1978), p282.

community's use of the asylum reflected their willingness to try out all available options when endeavouring to sort out common problems like subsistence and family discipline.

In considering these responses to the low-priority local institution, which was in many cases the typical incursion of colonial medicine into local societies and the point at which many indigenous people would have had their only contact with Western medicine, it is difficult to avoid the conclusion that colonial medicine was far from being a force for change. Rather than stimulating new forms of consciousness or political action the asylum comes across as an institution which was itself colonized and reshaped by the routine concerns of local society.

CHAPTER VI.

Indians inside Asylums: staff, patients and power.

> He refers in a loud, screaming voice + extra anger to my having once had him put into a bag for restraint. When I smiled he said as much as,
>
> 'Now laugh, I will make you cry'.
>
> They say he is never violent except when he sees Europeans, though sometimes he gets angry. He has not been so angry for a very long time. They say he sometimes gets abortive attacks of epilepsy. The Hosp. Asst. has not seen them.[1]

Such episodes, this one taken from the case note for Jeeobadh Koomar who was admitted to the Lucknow asylum in 1869, demonstrate the difficulties and also the possibilities of exploring the responses and reactions of Indians within the asylum. The first point to note is that much of the information that the British medical officer has recorded on the case note about the patient comes from Indians, the 'they' in the case note being the attendants at the asylum who would have been employed from the local population. The fact that it is they who can supply the information on the patient's usual state, that he is 'never violent', and it is they who can point out the exceptions to this rule emphasise that it was Indian personnel rather than the single British doctor who had the day to day contact with the inmates of the asylum and who would have been in charge of the routines of the place.

The second issue that arises is the question of whether the ramblings of a lunatic or his/her explosions of anger are representative of anything more than the tussles of a disturbed individual with his/her personal demons and delusions. There are three interconnected responses to this.

The first is that any attempt to discount the experiences of those who are mad on the basis that they are lacking in reason or that their responses to the world are non-rational is an endorsement of the much discredited reification as the only proper subject in history of the "unified and freely choosing individual who is the normative male subject of Western bourgeois liberalism".[2] Shirley Orter, for example, points out that this subject, "the freely choosing individual, is an ideological construct, in multiple senses- because the person is culturally (and socially, historically, politically and so forth) constructed; because few people have the power to freely choose very much; and so forth".[3] To dismiss the experiences of the mad because they were mad

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[1]Case Book IV, patient no.42, admitted 27 February 1869.
[2]Z.Pathak and R.S.Rajan, 'Shahbano', in *Signs*, 14, 3, 1989, p572.
[3]S.Ortner, 'Resistance and the Problem of Ethnographic Refusal', in *Comparative Study of Society and History*, Vol.37, 1995, p185.

is to comply with discourses developed in the nineteenth century in the West which relegated madness to an illness and thereby emptied that state of significance. This was a period described as one when

> compared to the incessant dialogue of reason and madness during the Renaissance ... silence was absolute; there was no longer any common language between madness and reason.[4]

Such a concern is not necessarily pertinent here though, as a second response to the idea that the actions and words of those deemed lunatic might not be representative of anything more than private and personalised nightmares is that in the Indian asylums it is rarely clear that those incarcerated in the institution were indeed insane. As was suggested earlier the people inside the asylum were there for political and social rather than medical reasons, in as much as British doctors, magistrates or jailors, or indeed Indian individuals, elders or husbands, had sought to negotiate behaviour that was to them deviant (rather than insane) or situations that were to them threatening, through use of the asylum.

That is why the above case note is so important, as it is one of the few which makes explicit the connection between the 'lunatic' classification and the political nature of the behaviour that has led to that classification and it serves to remind that the designation of an individual as a lunatic was apt to conceal more than it was to reveal. As with the designation of an act as 'criminal' so with the designation of an act as 'lunatic', in as much as the gesture denies the action political significance or meaning. The medicalisation of an action empties it of importance as it transforms it into a symptom of a disorder to which the normal individual is being subjected and serves to deny that it is the deliberate and direct statement of opposition of a fully functioning person. Hence, Jeeobadh Koomar's fury and anger at Europeans is neutralised by his being medicalized, instead of his violence being the forceful expression of anti-colonial antipathy and his threat being a potent statement of rural India's desire to subvert and avenge the colonial relationship it is reproduced on a case note as the utterings of an "excitable idiot".[5] In this light, to disallow the experiences and voices of the Indians who were classified as 'lunatics' is to become implicated in the process where "colonial power exercised itself in part through its capacity to silence the historical

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[4]M.Foucault translated by Richard Howard, *Madness and Civilization: a history of insanity in the age of reason*, (Routledge London 1989), p262.
[5]Case Book IV, patient no.42, admitted 27 February 1869.

record of the subaltern classes, representing spectacular forms of popular resistance as pathologies".[6]

A third point that might be raised in connection with the issue of how to interpret the actions and reactions of those deemed lunatic is that those who were truly insane raise interesting questions in discussing questions of historical agency. Without going into the question of what madness is at length here it would seem that there are certainly those who have organic conditions which result in variations on the standard model of brain structure and which act to influence their behaviour.

An example of such an organic condition would be meningoencephalitis of tertiary syphilis[7] or what was called in the nineteenth century 'general paralysis of the insane'. The impact of the disease on the structure of the membranes of the brain has behavioural ramifications: "Confusion and impairment of memory are common. The patient becomes inefficient, often anxious and nervous and may be thought to be neurotic".[8]

This behavioural evidence of a physiological state when placed in a social context might easily be interpreted as a reaction to that context, as with Peloo, a case reported as 'paralysis of the insane' by Dr. Wise in the *Indian Medical Gazette* in 1869.

> While under observation at Gowhatty, the civil surgeon reported that he had an incoherent and unsettled manner; that he talked nonsense, that he objected to wear clothes, that he wallowed in the mud, that he was threatening in his behaviour, and very capricious as regards food.[9]

His behaviour in the dispensary could well be seen as resistance of the order in the colonial hospital, as he refused to adopt the dress of the institution, reply in coherent ways and indeed seems to have been positively aggressive on occasions. Yet if this case was correctly diagnosed then Peloo's behaviour was simply a manifestation of a reordering of the structures of his body. Indeed, there is every reason to suppose that the diagnosis was indeed accurate as the post-mortem account included by Dr. Wise does include observations on the state of the brain which suggest some sort of cereberal transformation:

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[6]N.Dirks, G.Eley and S.Ortner (eds.), *Culture/Power/History: a reader in contemporary social theory*, (Princeton University Press 1994), p19.
[7]C.Quétel (translated by J.Braddock and B.Pike), *History of Syphilis*, (Polity Press 1990), p160.
[8]J.Walton (ed.), *Brain's Diseases of the Nervous System 10th Edition*, (Oxford University Press 1993), p291.
[9]J.Wise, 'General Paralysis of the Insane', in *Indian Medical Gazette*, Vol IV, 1869, p76.

> The membranes were not coherent. The arachnoid was found distended by a jelly-like effusion, which here and there was of a milky colour,[10]

An example like that of Peloo is interesting in light of recent discussions of historical agency. These have reached the stage where

> from a theoretical point of view we need a subject who is at once culturally and historically constructed, yet from a political perspective, we would wish this subject to be capable of acting in some sense 'autonomously' not simply in conformity to dominant cultural norms and rules, or within the patterns that power inscribes. But this autonomous actor may not be defined as acting from some hidden well of innate 'will' or consciousness that has somehow escaped cultural shaping and ordering. In fact, such an actor is not only possible but 'normal' for the simple reason that neither 'culture' itself nor the regimes of power that are imbricated in cultural logics and experiences can ever be wholly consistent or totally determining ... every actor always carries around enough disparate and contradictory strands of knowledge and passion so as always to be in a potentially critical position. Thus the practices of everyday life may be seen as replete with petty rebellions and inchoate discontent.[11]

While a difference between the 'passion' that is identified by the authors as an important factor in the disruption of the cultural and historical determinants and the 'will' that transcends and must therefore not be mentioned is not made at all clear the above statement could be read as wishful thinking or indeed an attempt by verbal sleight of hand to reintroduce the transcendent 'will'. However, it might be suggested that novel mental states caused by physiological factors could account for the actions and attitudes of individual agents which serve to disrupt and distort the cultural and historical structures. In other words, the 'passion' of individuals which results in them acting as agents to creatively interact with the environment of their communities and lifestyles can be accounted for without reference to an innate and essential human 'will'. A study of those in whom the organic factor in behaviour and mental functioning is most evident demonstrates that there are other factors behind human actions and perceptions than cultural and historical circumstances.

Overall then, there are a variety of reasons to explore the experiences and responses of those Indians inside the asylum. These explorations will first look at the Indian workers in the colonial institution and will then focus on the responses of those Indians incarcerated by the British authorities.

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[10]J.Wise, 'General Paralysis of the Insane', p76.
[11]N.Dirks et al., *Culture/Power/History*, p18.

The Asylum Staff.

It has been suggested that it is the attendants and wardens that lived within the asylums who hold the key to understanding asylum experiences rather than the professional medical men who were given the charge of the institutions but rarely visited or chose to organise from a distance. In an important article Richard Russell points out that

> the nursing staff were indeed the backbone of the asylum... for a brief time during the latter part of the nineteenth century it seems reasonable to suppose that the nursing staff were the most vital part of the whole asylum business.[12]

Indeed he goes on to conclude that "it may be that the asylum system upon which the whole lunacy profession rested ... was being slowly transformed by new ideas brought from below, by the nursing staff, whose origins and attitudes the men at the top were not fully able to control".[13]

This idea, that the subordinate staff had considerable power in the day-to-day routine of asylum administration which may have served to transform in practice the regimes and schemes devised in isolation by the medical profession is especially interesting in the colonial context where the subordinate staff would have consisted largely of members of the colonised population. Yet this is a relatively undeveloped theme both in the work on asylums in the colonial context and indeed in studies of medical administration in the colonial context as a whole. Harriet Deacon does mention the staff at the asylum on Robben Island but only in the context of a pay dispute amongst European subordinates[14] and Waltraud Ernst concedes that in India "only in 'native lunatic asylums' were Indian assistants customarily entrusted with the day-to-day care of Indian and lower-class Eurasian patients".[15] However she does not explore the implications of this situation. David Arnold mentions an interesting incident where "the most menial servants of Western medicine",[16] the Doms who worked in the dissecting rooms of the College Hospital in Calcutta, resisted the attempts of the

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[12]R.Russell, 'The lunacy profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum', in W.Bynum, R.Porter and M.Shepherd (eds.), *The Anatomy of Madness: essays in the history of psychiatry*, vol.III, (Routledge London 1988), p312; see also L.Monk, 'Working like Mad: nineteenth century female lunatic asylum attendants and violence', in *Lilith*, no.9, Autumn 1996, pp5-20.

[13]R.Russell, 'The lunacy profession and its staff', p312.

[14]H.Deacon, *A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910*, (Cambridge unpublished thesis 1994), pp100-101.

[15]W.Ernst, *Mad Tales from the Raj: the European insane in British India, 1800-1858*, (Routledge 1991), p106.

[16]D.Arnold, *Colonizing the Body: state medicine and epidemic disease in nineteenth-century India*, (Oxford University Press 1993), p6.

British to conduct a post-mortem on one of their own number but he uses this as a pretext to explore Indian society's reactions to Western medicine as a whole rather than to examine the impact on medical institutions of such resistance by subordinate medical staff to the designs of doctors.

The most comprehensive attempt to explore the experiences of members of the colonised population who acted as medical subordinates is a study done by Maryinez Lyons of African auxiliaries in East Africa. Lyons shows how the intentions of the European authorities in instituting medical programmes and facilities were often frustrated by the auxiliaries who were sent out to administer them. These Africans had their own agendas which they pursued using the power and the resources available to them as representatives of state medicine, "the biomedical technology was especially attractive to individuals who wished for status and influence",[17] and which would result in preferential access to treatment for certain social groups, the development of a market in pilfered medical supplies and so on. This pursuit of agendas independent of those of the coloniser with the result that colonial schemes became distorted or were even thwarted is a theme that seems pertinent in looking at the experience of the asylums for Indian patients in British India.

It is clear that by 1880 the Indian staff of asylums were considerable bodies of people. At the largest of the asylums at Dullunda near Calcutta the staff under the British medical officer was as follows:

1 Deputy Superintendent.
1 Matrob.
1 Writer.
1 Native Doctor.
1 Compounder.
5 Jemadars.
24 Keepers.
2 Hospital keepers.
4 Durwans.
1 Hukara.
1 Lamplighter.
1 Mallies.
3 Cooks.
1 Baker.
1 Washerman.
12 Mahters.
6 Mehteranis.

[17]M.Lyons, 'The Power to Heal: African medical auxiliaries in colonial Belgian Congo and Uganda', in D.Engels and S.Marks (eds.), *Contesting Colonial hegemony: state and society in Africa and India*, (British Academic Press 1994), p222.

2 Barbers.
3 Bhistees.[18]

In the year 1880 this staff had to attend to a daily average of about 215 patients. Even in the smaller institutions the staff were fairly numerous. At Delhi in 1880 there were 73 patients in the asylum at the end of the year and the staff were listed as:

1 Deputy Super.
1 Native Doctor.
1 head Warder.
2 1st Class Warders.
3 2nd Class Warders.
3 3rd Class Warders.
3 4th Class Warders.
1 Cook.
1 Assistant-Cook.
1 Gardener.
1 Bhisti.
1 Dhobi.
2 Sweepers.
1 Barber.
1 Matron.
2 Assistant Matrons.[19]

The staff in the smaller institution numbered 25 then and like the larger institution the patient to staff ratio was about 3:1. It is not difficult to see then how the day to day running of the institution was almost entirely in the hands of Indians. Only in the instance of the asylum at Madras does a European medical officer appear to have had the asylum as his sole responsibility in this period so it was only there that the asylum would have had the constant presence of a British medical officer. It was the norm that the local Civil Surgeon should have the charge of the asylum as just one of his many duties. The time and attention that the asylum received from such an officer is likely, through sheer pressure of work, to have been minimal. J.Howard Thornton, who was a Civil Surgeon in India in the 1870s, wrote in his memoirs of the tasks that the medical officer of the station was expected to attend to.

> The day after my arrival I took over my duties which included the management of the district jail, containing more than four hundred prisoners, as well as the superintendence of the Arrah dispensary, and several branch dispensaries in different parts of the district, the medical charge of the district police and other civil establishments and a fair amount of private practice in the station and neighbourhood... In addition to the various duties pertaining to the office of Civil Surgeon... I was one of the municipal commissioners of the town of Arrah... I was also a member of the district school committee .. I was ex-officio, police surgeon, and all

[18] *Annual Report of the Insane Asylums in Bengal for the Year 1880*, p36.
[19] *Annual Report of the Lunatic Asylums of the Punjab for the Year 1880*, p12.

> examinations of police cases as well as post mortem examinations had to be performed by me ... quarrels and fights about boundaries, water, straying cattle, grazing rights, and many other disputed matters were so common in that part of India that nearly every day I had to examine persons who had been injured in these conflicts ... All these cases involved my subsequent attendance in the different courts of justice for the purpose of giving medical evidence.
>
> It will thus be seen that the time of a Civil Surgeon in India is pretty well occupied even in an ordinary station like Arrah. In a large station like Patna, where the Civil Surgeon has in addition a lunatic asylum under his charge, and a medical school to superintend the work is much heavier and some of it must necessarily be left in the hands of subordinates.[20]

Sometimes one of these subordinates at the asylum would have been a European in the capacity as Deputy Superintendent or Overseer, and the reports for Patna throughout the 1870s suggest that such a number sometimes doubled:

> Mr.Nowlan as Overseer and Mrs.Nowlan as Matron worked steadily and faithfully throughout the year, and I have much pleasure in commending them to the Surgeon General.[21]

In these cases there would have been a constant European presence at the asylum, albeit a small one. However, the same report from Bengal in which that statement was made also includes the following remarks about the asylum at Berhampore: "The Overseer, Baboo Mohendro Nath Roy, regarding whose character and fitness for the post he occupies I have fully expressed in former reports, continues to perform his duties in an efficient and honest manner".[22] It would seem then that even the most senior of the staff who were permanently at the asylum could sometimes be Indian.

The composition of the Indian staff seems to have been rather mixed. There are hints that some of the Native Doctors were formerly attached to military units: "1st Class Hospital Assistant Lutchman Singh still maintains the high opinion I found regarding him on the occasion of previous reports, and he has seen much service and was in the Bailey Guard during the Mutiny",[23] reported Dr. Cannon at Lucknow in 1872. Similarly at the asylum in Dullunda Dr. Payne noted that "the native doctor of whom I had reported unfavourably was moved during the year and his place supplied by Sheikh Bahadoor, a man who bore a high character in the military service".[24] Indeed the military connection was evident in the making up of the subordinate staff.

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[20]J.H. Thornton, *Memories of Seven Campaigns: a record of thirty-five years' service in the Indian medical Department in India, China, Egypt and the Sudan*, (London 1895), pp168-172.
[21]*Asylums in Bengal for the Year 1878*, p23.
[22]Ibid., p27.
[23]*Annual Inspection Report of the Dispensaries in Oudh for the Year 1872*, p28.
[24]*Asylums in Bengal for the Year 1869*, p4.

> The conduct of the native establishment has been excellent. Slowly progressive change has taken place under the present scale of wages in the class of men who take the service. Some of the new men had served in various capacities under the overseer in the horse artillery in former years. A few are Punjabees who have taken their discharge from regiments quartered in this neighbourhood and being contented with the service have summoned others from long distances. The general result is that a staff of servants very different from, and in every respect greatly superior to, that of former days is in course of formation ... [25]

In a similar vein the staff at Hazaribagh seem to have seen service elsewhere in the British system, a fact which comes to light in a report where the superintendent "expresses the obligation he is under to Mr.Parry Davis, District Superintendent of Police, who procured jemadars for him (three of whom were police head constables of superior character) and arranged a comprehensive system of discipline as to reliefs etc.".[26]

However, it was not the case that the asylum staff was invariably drawn from ex-servicemen. Dr. Fairweather at the Delhi asylum bemoaned the fact that "there is not much to be said about the barkandazes and keepers, who, from the smallness of their pay, are generally men who have failed to get employment elsewhere".[27] Likewise, the Inspector-General of Prisons in Burma whose responsibility it was to staff the asylum at Rangoon was disdainful of the class that the pay on offer would attract but he had devised a way of getting around this.

> As will be noticed, I have introduced a large convict element into the constitution of the establishment; and I have done so, because in the first place, I consider that by this measure the Chief Commissioner's instructions to observe the strictest economy in framing my estimates may be closely adhered to; and in the second, because the Asylum will in this way obtain in its minor offices the services of men much more trustworthy, much more intelligent, and much more orderly than any whom it is possible to find amongst the class of free natives of India which alone would be disposed to take service in the institution.[28]

Whatever the exact constitution of the Indian staff in the various asylums however, it is clear that as Indians made up the bulk of the staff in all the asylums who routinely dealt with the inmate population and often held positions of seniority and responsibility within those institutions, they were in a position to frustrate the plans of the medical officers for the patients and that they did indeed resist and subvert colonial agendas. They did this in two interconnected ways, by refusing to meet the basic

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[25] *Asylums in Bengal for the Year 1869*, p5.
[26] *Asylums in Bengal for the Year 1876*, p35.
[27] *Asylums in the Punjab for the Year 1876*, p19.
[28] Extract of letter from IGP British Burma 28 September 1870 in GOI (Public) Procs 8 April 1871, 38-39A.

demands of work-discipline expected by the British and by actively disrupting the treatment regimes devised by the colonial authorities.

The basic demands of colonial work-discipline or what has been called the "norm of [the] conscientious worker",[29] seem to have been often ignored by the asylum staff who were reluctant to give their all for so little reward. Some instances of this seemed fairly innocuous even to the British superintendent, Dr. Birch for example reporting that "the keepers and other subordinates, on the whole, worked well. Sleeping while on watch at night is their chief offence".[30] The attendants at Patna seem to have incurred the displeasure of the superintendent there with some regularity, so that in 1878 for example the end of year report noted that "three jemadars, eleven keepers and two mehters were fined for petty offences, one jemadar resigned, one washerwoman and one carpenter were dismissed for neglect of duty".[31] The medical officer at the Delhi institution gave an account of his staff in 1875 which shows how Indian personnel consistently resisted attempts to impose on them schedules and duties which did not suit them:

> The barkandazes and keepers are indolent and troublesome. I cannot get them to be careful with or vigilant over the patients. They are repeatedly being fined for staying away without leave beyond hours, for neglect, untidiness and remissness in guarding and tending the lunatics.[32]

Neither was resistance to the work-discipline expected by the British medical officers in the asylum restricted to those Indians working in the menial positions in the institutions. The superintendent at the Dullunda asylum wrote in 1870:

> The native doctor of whom I had reported unfavourably was moved during the year and his place supplied by Sheikh Bahadoor, a man who bore a high character in the military service, and I have no doubt deserved it; but the hospital system of a regiment does not create the habits that are required in the asylum. There cases of illness are brought to the hospital or to the notice of the subordinate, whose business it is to attend only where his attention is called for. Here he is mainly useful in spontaneously searching for illness among the inhabitants of the place, without which search it often progresses unknown. To keep up an unremitting search for illness throughout the day is a practice which does not commend itself to the understanding or the inclination of a man who is accustomed to consider his day's work done, or nearly so, when the surgeon's visit is over ...[33]

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[29]R.O'Hanlon, 'Recovering the Subject: Subaltern Studies and histories of resistance in colonial South Asia', in *Modern Asian Studies* 22, 1, 1988, p214.
[30]*Asylums in Bengal for the Year 1877*, p134.
[31]*Asylums in Bengal for the Year 1878*, p23.
[32]*Asylums in the Punjab for the Year 1874*, p12.
[33]*Asylums in Bengal for the Year 1869*, pp4-5.

The hint of frustration in the passage would seem to suggest that Sheikh Bahadoor was withstanding the efforts of the superintendent to transform his working habits from that of waiting in the infirmary for new cases to arrive to that of active surveillance of the institution's population. Similarly in 1871 the report for the asylums in Bengal for the previous year concentrated on the comments of the superintendent at Dacca:

> The native doctor, Sheikh Abdoollah, whose conduct is unfavourably commented on, has been removed, and a more promising young man appointed. On the subject of native doctors for lunatic asylums, Mr. Buckle remarks as follows in his covering memorandum:- 'The fact is, that a higher amount of intelligence, and a more careful performance of their duty, is required both from the native doctor and the attendants at a lunatic asylum than in any other situation. It is almost impossible to make the native doctor understand that it is his business to be constantly watching the insane, to notice who is sick, who more dull and depressed than usual, and that his duty lies far beyond waiting at the hospital until the sick are brought to him. I certainly think that the pay of the native doctor is too low to secure or retain a good man. The duties here are far more difficult and responsible than those in a jail hospital, where the pay is the same-Rs.25. I think the at least Rs.40 should be the salary of asylum native doctor where the number of inmates exceeds 100.[34]

Again then there is the sense that even the senior members of staff at the asylums were capable of ignoring British attempts to get them to take on more work for much the same money.

Naturally any refusal by the Indian staff in the asylums to take on work or to perform the tasks that the British expected of them in the asylum would have implications for the efficacy of the treatment regimes that were discussed in the last chapter. Indeed there is plenty of evidence that these treatment regimes were actively subverted by the Indian staff.

There were various means by which the British made the asylum staff aware of what they were supposed to be doing so that any failure by the staff to perform certain tasks can be seen as conscious refusal rather than unwitting non-compliance. As has already been suggested there was a fine system operating in many asylums where failures to perform the expected duty were penalised, and in this way Indian staff would have learnt what was expected from those of whom an example was being made. More positive attempts were made however to school the staff in what they were being employed to do. For example as early as 1856 the superintendent had set out a clear set of instructions for the asylum staff and the means by which they would be made aware of these instructions, even if they were illiterate.

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[34] *Asylums in Bengal for the Year 1870*, p18.

Rules for the Guidance of the Subordinate Establishment of the Asylum at Dullunda

i. The European Overseer, the Native Doctor, and Servants male and female, are strictly enjoined invariably to treat the patients with the greatest kindness; to abstain from harsh language, threats, abuse, all acts of oppression, blows or any other acts. They are to remember that the unfortunate patients are of unsound mind and not responsible agents.

ii. When the conduct of a Patient becomes violent and dangerous to himself and others, the Hospital Servants will, in the absence of the Super, report the circs to the Overseer who will immediately visit the patient. Should the overseer consider restraint to be absolutely necessary for the safety of the Patient himself or others, temporary seclusion may accordingly be applied. But in such case, the Overseer will report the circumstance to the Superintendent.

iii. Clubs, sticks, weapons, sharp edged or pointed tools are strictly prohibited from being introduced into the Asylum.

iv. Such patients as may be permitted to assist in the kitchen and garden are not to be trusted with knives or tools with which they may commit injury.

v. Visitors to the Patients are to be admitted with the permission of the Magistrate of the 24 Pergunnahs or of the Superintendent.

vi. All complaints relating to the Patients or to the Hospital Servants are immediately to be brought to the notice of the Overseer, who will take the earliest opportunity to report to the Superintendent.

vii. The overseer will see that the preceding rules are strictly observed and a copy in English and in Bengallee is to be kept suspended in the office. The native Doctor will at the monthly Muster read to the Hospital Establishment a Bengallee translation of he preceding rules.

signed, T.Cantor and H.D.H.Fergusson, Fort William Jan 1 1856.[35]

Instructions seem to have been issued elsewhere, the superintendent at Bareilly stating that "I need hardly say that no violence on the part of the attendants is ever allowed, and they understand that a blow, or indeed any kind of harshness or rough usage is visited by immediate dismissal".[36] Some asylums seem to have gone further than simply issue a series of orders and devised ways of skilling their staff. For example, the Surgeon General in Madras noted in 1874 that, from the asylum at Vizagapatam, "a Head Warder, with one female and two male warders, were sent for special training in the Madras Institution".[37]

While there is evidence that the Indian staff at the asylums received at the very least instructions as to what to do in the asylum if not actual training in how to go about

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[35]'Reports on the Asylums for European and Native Insane Patients at Bhowanipore and Dullunda for 1856 and 1857', in *Selections from the Records of the Government of India* no XXVIII, p63.
[36]'Annual Reports of the Lunatic Asylums at Bareilly and Benares for the Year 1867', in *Selections from the Records of the Government of the North-Western Provinces*, p59.
[37]*Annual Report of the Three Lunatic Asylums in the Madras Presidency during the Year 1873-74*, p13.

their jobs, there is certainly also evidence that the staff often did not create on the ground the asylum environment that the British medical officers described in their reports as desirable.

In an annual report for the asylum at Waltair the superintendent pointed out that the

> conduct of warders and servants has been upon the whole fair, with three exceptions, a male warder, female warder and female cooly who were dismissed and prosecuted for striking patients. I hope these dismissals and prosecutions- in each case a conviction was obtained- will act as a deterrent against the commission of such offence in future.[38]

Similarly at Benares the superintendent had to report in 1867 that "one of the two Jemadars was dismissed some months ago for striking a patient",[39] and at Dacca "the keeper who struck a lunatic in the face with his fist was reported to the police, and a local enquiry was made, but the case went no further for want of legal evidence. He was nevertheless dismissed".[40] Perhaps most illustrative of all was the case brought up by Dr. Payne at Dullunda, the asylum where the system of reading out the rules to the staff had begun in the 1850s:

> For the first time during an incumbency of ten years I am compelled to report a death from violence. A maniac was brutally ill treated by a peon, and died from the effects of it. The peon was convicted and imprisoned and thus was obtained the only possible satisfaction which can follow the occurrence of such a case.[41]

It was demonstrated in Chapter IV that the British intended to have the asylum regime in India based on firm but kind treatment in keeping with contemporary views on the management of the insane in Europe. Indian staff showed themselves more than capable of frustrating these designs and disrupting that regime. Indeed, other elements of the British plans for the treatment of the inmates were resisted by the attendants. Putting the inmates to work was an important component in the ideal system yet the superintendent at Delhi wrote a report in 1876 suggesting that it had been difficult to get the staff there to cooperate with him in setting up projects for the incarcerated:

> In the treatment of the insane the chief reliance has been put upon healthy occupation and amusement. After a long struggle, and with every kind of opposition thrown in the way by the Asylum establishment, I at last succeeded in starting some manufactures in July last.[42]

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[38] *Asylums in the Madras Presidency during the Year 1877-78*, p25.
[39] 'Asylums at Bareilly and Benares for the Year 1867', p47.
[40] *Asylums in Bengal for the Year 1878*, p7.
[41] *Asylums in Bengal for the Year 1870*, p12.
[42] *Asylums in the Punjab for the Year 1876*, p11.

The agendas, even survival strategies, of Indian attendants is most obvious in the frustration of a further element of the asylum regime which had as its focus the body of the inmate. The medical officers thought that attention to diet in order to establish physical health in the patient was central to a successful asylum. The superintendent at Delhi stated in 1870 that "the diet has been liberal. Good, well ground wheaten flour chappaties, fit for any breakfast, four each- three in the morning and one in the evening- together with dall and vegetables four times a week, and a stew of meat and vegetables three times a week".[43] He pointed out again in 1872 that "good feeding, great kindness and indulgence of every harmless kind"[44] were the central tenets of his institution.

The statement in the report of 1875 comes as some surprise then.

> I regret I cannot report favourably about the subordinate establishment. The assistant matron, the cook and a keeper have been discharged for stealing the lunatics food and several of the burkundazes and keepers have been fined or dismissed for carelessness or harsh treatment of the lunatics under their charge.[45]

In other words certain of the staff had taken the opportunity that access to the supplies of the asylum gave them to supplement poor incomes with acquired perks. This opportunism was not restricted to the staff in Delhi either. Surgeon-Major Birch at Hazaribagh in Bengal complained in 1878 that "two cooks have been summarily dismissed for this offence and another was prosecuted, but that pilfering still goes on I fear is the case, notwithstanding the measures taken to prevent it. Only a few days ago the Overseer detected two of the cooks stealing the meat which ought to have been issued to the patients".[46]

While such theft can be linked to the survival strategies of the subordinate staff it may well be that there were other reasons for them to be removing certain items of the patient's diet. While the superintendent may have been extolling the virtues of 'a stew of meat and vegetables three times a week' it may have been that few others in the asylum shared his enthusiasm for cooked flesh. Most Indians would have been committed to a vegetarian diet for cultural and religious reasons in this period and as was suggested in the previous chapter the British medical officer may have been simply ignorant of this or indeed could have had ulterior motives for including meat in

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[43] *Asylums in the Punjab for the Year* 1870, p15.
[44] *Asylums in the Punjab for the Year* 1871-2, p5.
[45] *Asylums in the Punjab for the Year* 1875, p3.
[46] *Asylums in Bengal for the Year 1877*, p29.

the inmate's meals. The possibility is raised, in the above example at least where it is specifically the meat which is being removed by the cooks, that the Indian staff were actually subverting the superintendent's designs for the benefit of the inmates. Mindful of the fact, which was explored in the previous chapter, that a refusal to eat what was presented to them could often result in punishment or forced feeding for the inmates it could be that the staff were acting out of sympathy for the patients by removing the offending flesh before it was presented to them as their dinner.

Whatever the explanation in this example, it seems certain that the bodily treatment of the asylum regime was often disrupted by those members of the establishment who were supposed to administer it. Indeed as the set of statements from Delhi shows, the rhetoric of the superintendent and the asylum reports about the systems operating within the asylum was often only that, as the decisions of staff, who often had their own ideas about what should go on, actually determined conditions and experiences on the ground. While the reports of the superintendent claimed that 'good feeding' and 'great kindness' was the basis of the preferred asylum regime it appears from those reports that the staff were actually removing the food and sometimes dealing severely with the patients.

It must be remembered that this power to shape events within the asylum was not always used by Indians to resist the designs of the British. Often the response of the staff seems to have been to work hard to make the regime tick over and to make sure that the asylum ran smoothly. While certain of the 'native doctors' mentioned above seem unwilling to take on the additional tasks connected with serving in an asylum there were those who were happy to muck in. Surgeon Major Shircore reported:

> Native Doctor Rutoo is well spoken of, having been attached to the Moydapore dispensary for 29 years, and has been attached to the Berhampore Asylum since its opening in 1874. He is well acquainted with all the details of duty, and his willingness to help in the general management of the lunatics renders him a useful officer.[47]

The civil as opposed to the medical staff could also show considerable accomplishment in their roles, the superintendent at Cuttack being happy to note that "the conduct of the establishment during the year has been uniformly good. The darogah has been in charge for the past 15 years and has performed his duties to my entire satisfaction; he possesses remarkable tact in managing the insanes and in

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[47] *Asylums in Bengal for the Year 1877*, p27.

keeping the minor establishment up to their work",[48] while in his report for the same year the superintendent at Dullunda insisted on including the following note:

> The head clerk, Oparva Narain Bhattacharjee has been indefatigable throughout he year, giving in time of need much more time and labor to the asylum than can be legitimately demanded of him, and never complaining however heavy the additional calls have been or however irregular his hours of rest.[49]

Some staff were considered indispensable because of their personal qualities. In 1870 the Deputy Inspector-General of Hospitals in Lucknow wrote that "Dr. Cannon reports very favorably of 1st class Native Doctor Luchman Sing; but he is bent with age and disease and I only refrain from invaliding him on account of Dr. Cannon's assurances as to his efficiency and usefulness, and knowledge of the working of the institution".[50] It was explained in 1874 by Dr. Cannon, by then the Deputy Surgeon-General of the Lucknow Circle that

> the conduct and qualifications of First Class Hospital Assistant Luchman Singh have always been reported well of by every medical officer under whom he has served, and I quite endorse the opinion of Dr. Ray that although old and a sufferer from chronic rheumatism, he is admirably qualified for managing insanes both from his superior tact and good temper, and on this account his services are more valuable in an Asylum than those of a younger and less experienced man.[51]

It seems that often Indians were willing to take on the extra work associated with employment in the asylum, to devote extra hours to their duties where necessary and to ignore the debilities of age and infirmity in order to get on with their jobs at the asylum.

There are obviously difficulties in dealing with this sort of evidence and in deciding what was going on in the asylums. The accounts of the medical officers could be dismissed as self-serving and written to give impressions of competence, so that commendation of subordinates might be exaggerated or individual attendants might be given the blame in order to show the superintendent in a better light. There is no doubt an element of this in the reports, although there was a system of Visitors where local civil and medical officers would inspect institutions like the asylum which would have made consistent subterfuge by the superintendents more difficult and indeed there are instances where the management of institutions is called into question. So for example, the dietary scale in the Dullunda asylum became a matter of some

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[48] *Asylums in Bengal for the Year 1878*, p24.
[49] Ibid., p15.
[50] *Dispensaries in Oudh for the Year 1869*, p2.
[51] *Dispensaries in Oudh for the Year 1873*, p3.

controversy in 1869 after the Inspector-General of Hospitals in the Lower Provinces of Bengal complained that "I noticed also that very many of the insanes are exceedingly anaemic and cachetic and there is no doubt in my mind ... that the system of dieting carried on for a long time in this asylum was a thoroughly inadequate one in relation to the amount of actual labor performed".[52]

What cannot be doubted is the fact that Civil Surgeons had many other calls on their time in the station and that for larger parts of the day, if not the week, the asylum was in the hands of Indian subordinates and the inmate population was subject to their supervision rather than the direct control of any colonial. To underline this it is worth mentioning that the rules for the Lucknow asylum, at which Luchman Singh held sway despite his rheumatism, demanded only that "the superintendent shall regularly visit the Asylum at least three days in each week".[53] In these circumstances the Indian staff would have had considerable scope for making decisions and pursuing agendas independent of those sanctioned by the British officers. Significantly the decisions they made and the agendas they pursued often served to undermine the avowed intentions of the asylum regime despite evidence that they had indeed been made aware of those avowed intentions. It is not difficult to see these as examples of Indians resisting the coloniser's power to order even their own institutions.

However, just as significant is the fact that many Indians worked in the institutions to the satisfaction of the British, satisfaction that appears to be justified where it appears that the results can be measured in material terms. The sale of articles produced at the Dullunda asylum reaped Rs.7205[54] for the asylum in 1880 with an average daily population of 215 and this is just an extreme example of a system that was operating throughout the asylums of India by the end of the 1870s where even the smaller institutions proved themselves sufficiently organised to produce goods worth over Rs.1000 per annum.[55] The design of such operations might be attributed to the British medical officer but the routine administration of them cannot when it is recalled that he had so much else to do. This administration would have devolved on the subordinate staff who were in the asylum on a daily basis and would have been, with the occasional exception of a European overseer, completely drawn from the Indian community. Superintendents acknowledged as much in their reports, Major Scriven at

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[52]*Asylums in Bengal for the Year 1869*, p7.
[53]Gvt.Oudh to GOI 12 August 1868 3403, in GOI (Public) Procs December 19 1868, 25A.
[54]*Asylums in Bengal for the Year 1880*, p37
[55]Ibid; Cuttack produced goods sold off for Rs.1223 in 1880 with an average asylum population of just 51 patients.

Lahore making a point of thanking his staff on the occasion of his return to Britain and emphasising that

> not less to be commended are the jemadar, the compounder and the jamadarni. The jemadar, Mirza Hassam Ali, has been here 13 years. He thoroughly understands the work of the institution and we should have had great difficulty in carrying on the work without him.[56]

It must not be assumed however that these Indians were any different from those who chose to resist British orders and instructions. They were making the British system work for their own reasons and in pursuit of their own agendas. Sometimes these are obvious, as there are pecuniary rewards on offer for diligence.

> All the servants of the Asylum are at present good and respectable men, and understand their duties thoroughly. They are very badly paid ... so to encourage them I give them an extra rupee or two per month from the profit fund of the Asylum. I find this plan answers very well.[57]

Sometimes though they can only be speculated at. The status that a position in the colonial service or access to Western knowledge gave was part of the attraction that persuaded Africans to train as auxiliaries in Lyons's account of the medical services in Uganda and the Belgian Congo.[58] Maybe these factors influenced Luchman Singh's decision to work on into his old age, as the power of controlling a staff might have been difficult to relinquish or quite simply retirement could have been difficult to contemplate.

Whatever is the case, it is clear that the day-to-day running of the asylums was in the hands of predominantly Indian staff and that the Indian attendant could and did resist British attempts to circumscribe his conduct by the issuing of instructions and the threat of dismissal. The result of this would have been that the experience of the inmates of the institution was frequently determined by the agendas and decisions of Indian personnel rather than colonial directives.

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[56] *Asylums in the Punjab for the Year 1880*, p3.
[57] *Asylums at Bareilly and Benares for the Year 1866*, p33.
[58] M.Lyons, 'The Power to Heal', pp219-222.

Indian Patients.

> Although many insane persons on first admission yield themselves at once to the order and discipline of the place by the mere force of example and the imitative faculty, which is unimpaired, and take up without difficulty some one of the employments before them, there are others for whom occupation is no less necessary, who require the constant efforts of attendants to keep them at their work and who frequently offer both active and passive resistance. [59]

As with certain members of the Indian staff the patient population provide interesting examples of resistance to colonial strategies and objectives. These instances of resistance came in three forms, the verbal, the violent and the escape.

Any examples of Indians speaking in colonial documents is obviously problematic, as the methods by which their statements came to be translated, selected and recorded are rarely transparent. However, as was shown with the example of Jeeobadh Koomar which was the focus of the beginning of this discussion of Indian responses, the Indian voice can still raise interesting possibilities even where it is refracted through a colonial text. His case note records the moment when he threatened the medical officer who had ordered him restrained in a bag, and even if the medical officer had pared down the context or the content of the entire episode there is still a record of an important moment when the colonial medical officer's authority was contested.

The same might be said of the following passage which appeared in the annual report on the asylums in Bombay in 1874. In a general discussion on the merits of a system of labour in the management of insanes, the superintendent asserts that, "to us the best sign of improvement is the willingness to work".[60] He then mentions

> one Seedee, whose hopes of recovery are but small, wants to know if we take him for a coolee when we ask him to work; this man talks for hours to imaginary people.

In this example the patient is denied even a transcription of a translation of his voice and instead his statement is summarised by the superintendent and sandwiched in between two unequivocal confirmations of the man's irrational state. These confirmations offered by the medical officer are designed to silence and discredit the moment of resistance, these are part of the process of representing moments of resistance as pathologies. Nevertheless, the moment of resistance is still present in the

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[59] *Asylums in Bengal for the Year 1863*, p3.
[60] *Asylums in the Bombay Presidency for the Year 1873-4*, p44.

document and is vitally important as it confirms that patients did actively resist the British agenda of putting them to work.

Where prisoners would not work this was usually represented as being beyond their control. "Lunatics with the delusion of greatness strongly impressed on the mind are most difficult to induce to work",[61] insisted Dr. Simpson at Dacca thereby assigning their refusal to work to a special kind of lunacy. The case note for Rajoowa at Lucknow represents his unwillingness to work as an inability: "He was always quiet, never turbulent, but could not be persuaded to do any work- sometimes tried but had no jee [sic] for anything".[62] Even where the inmate was seen to be actively resisting work this was assigned to a failing rather than active reluctance. So for example, Ajjoddhia's case note states that he "occasionally can be induced to work, refuses apparently from laziness only".[63] By referring to 'laziness' here Ajjodhia's resistance to work is being linked with a series of racial discourses on the 'lazy native'[64] which was developed in the colonial encounter and which served to represent the refusal of the peoples that the Europeans encountered to fit in with their economic projects as evidence of racial weakness rather than overt resistance.

However Seedee's sense of indignation, which comes through even in a colonial document, at being requested to work at some menial task suggests that patients did actively resist the labour regime of the asylums of colonial India. Seedee is actually refusing to work as he sees it beneath him and his sardonic reply implies that he is making sure that those who expect him to work know that he is not malingering or incapacitated. In other words, he is not simply resisting the treatment strategies of the institution, he is making sure that those who expect him to work know that he is resisting them.

Perhaps the most difficult case of verbal resistance to interpret is that of Hyder Cooly, but if it is indeed a case then it offers a fascinating insight into the way that Indians could take advantage of the 'insane' identity, and the protection that that unusual status afforded them.

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[61] *Asylums in Bengal for the Year 1862*, p31.
[62] Case Book IA, patient no.142, admitted 14 October 1861: underlining in original.
[63] Case Book IA, patient no.210, admitted 24 July 1862.
[64] See for example, S.Alatas, *The Myth of the Lazy Native: a study of the image of the Malays, Filipinos and Javanese from the 16th to the 20th century and its function in the ideology of colonial capitalism*, (Cass London 1977).

> Some of them are very interesting from their humour and other peculiarities. One of these, well known to every visitor of the Asylum, is Hyder Cooly; this man has been for some years a cook to the European soldiers at Dinapore, where he acquired a vocabulary of about eighty or a hundred English words. On the occasion of any European visiting the Asylum, Hyder always addresses them in the most absurd jargon of broken English that can be imagined, his countenance lighting up by degrees to a broad grin. Looking the person he is addressing full in the face he generally ends a long rigmarole of incoherent talk with 'go to hell you black fellow' and then bursts into a loud laugh. But Hyder is not always in a comic vein; at times (but rarely) he is low and melancholy, and in tears; he does not then speak in English, but his lugubrious, odd expression is almost as ludicrous as when he is in a more happy mood.[65]

To ignore the possibility that Hyder's well practised performance is a spectacular example of a low status Indian joyfully abusing the local brass whenever he gets the opportunity is to comply with the project of the superintendent at Dullunda. Although tempted to pass on the vignette the officer still feels it necessary to emphasise, even in a report about lunatics, that the man in question was undoubtedly unstable and therefore not to be taken at face value and this explains the sentence after the punchline which seeks to discredit Hyder as 'odd' and 'ludicrous'.

A less circumscribed reading provides a fine example of an Indian happily berating Europeans from the protected status as a 'lunatic'. Only the previous year for example, the same superintendent who wrote the above account had written:

> Civilly incapable and criminally irresponsible the pauper lunatic in custody is exempt from retributive justice and for him sympathy disarms the law.[66]

Safe in this knowledge, Hyder Cooly launches into his diatribe using as much English as he knows, of which some would have been 'absurd' to the asylum Visitors who as officers might not have been familiar with many of the English words he had picked up from the infantrymen. Whether or not he was making himself clear, he knew that by drawing himself up, looking them square and issuing the order 'go to hell you black fellow' he had a great way to make his meaning clear. With a finale that turns the power relations that he has suffered throughout his life on their heads and which ends with a forceful curse, no wonder he allowed himself a loud laugh.

However difficult it is to interpret the voices of Indians which are embedded in sources exclusively authored by colonial officers, it is important not to ignore those fragments. Even where the documents seek to hide the meanings of Indian statements under layers of appropriation, translation and meaning, it is still possible to find

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[65] *Asylums in Bengal for the Year 1863*, p29.
[66] *Asylums in Bengal for the Year 1862*, p14.

instances where Indians verbally resisted the objectives and indeed the relationships of colonialism. A far more active way of resisting the objectives of the asylum though was to simply absent oneself from the institution altogether. Escape seems to have been a fairly common occurrence in some asylums. In 1877 the annual report for the Central Provinces noted that at the Nagpur asylum "two males discharged themselves by escape, and have not subsequently been captured".[67] It also mentioned that there had been one escape from the Jubbulpore, the other asylum in the administration. In 1878 there was a further escape from Nagpur, but none from Jubbulpore, in 1879 another from Nagpur and two from Jubbulpore and in 1880 Nagpur managed to keep its inmate population intact while Jubbulpore lost three who opted to 'discharge themselves by escape'.

Similarly in Madras there was a tendency for some inmates to opt for a voluntary early release.

> There have been four escapes, of whom only one was recaptured; all were harmless, quiet lunatics, and therefore evaded the vigilance of the warders, whose attention is more specifically directed to the troublesome and dangerous patients. No criminals effected their escape. To obviate the wandering away of the inmates, the aloe fence surrounding the asylum is being repaired and the trench deepened as the cost of a wall, which would alone effectually prevent escapes, is found too heavy.[68]

The superintendent's hopes for the repairs to the hedge and the trench were however dashed in the next twelve months, and indeed his faith in a wall also seems to have been brought into question.

> There have been five escapes during the year, three of whom were brought back, and of the remaining two, who were admitted as criminals, one was transferred to the ordinary list as his time of imprisonment had expired. These two patients made their escape by getting upon the roof of the latrine, and thence on to the main wall, from which it is supposed they let themselves down by cloths they had borrowed or stolen from other patients. Nothing has since been heard of them although the matter was at once reported to the Police authorities.[69]

Escapees sometimes opted not to give the asylum a chance to work on them and sought their escape without delay, the superintendent at Colaba reporting at one point that "one lunatic escaped through the ventilator in the roof of his small room three days after his admission into the asylum, and has not yet been captured",[70] while others decided to make a break for it despite being considered something of an asylum

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[67] *Asylums in the Central Provinces for the Year 1877*, p1.
[68] *Asylums in the Madras Presidency during the Year 1877-78*, p14.
[69] *Asylums in the Madras Presidency during the Year 1878-79*, p14.
[70] *Asylums in the Bombay Presidency for the Year 1876*, p18.

fixture: "A Gond, named Lalu from Chanda, escaped, though an old inmate of the asylum, and had always been considered harmless and quiet".[71]

That those who were escaping were not simply wandering off in a daze, but were actively attempting to resist incarceration in the institution is emphasised in the details in instances like the following:

> Moula Buy. Amentia. Servant. Mussul. 27. 7th Jan.
>
> 1861 Jany. A sepoy of the Meerut Regt.- imprisoned for some regimental breach of discipline, was some days in the Jail of Lucknow before transferred him to the asylum- is a slight, tall man of good address + very intelligent. Talks very incoherently + fancies that there was some combination against him.
>
> Feb 13th. Made his escape- apparently with the connivance of his wife- during the night + was some days afterwards brought back from Cawnpore whither he said he had gone to take the air + bathe in the Ganges but that he had suffered so much distress on the road that he would not repeat his walk for some time- is very restless + unsettled. Is no longer a prisoner.
>
> April 13th. In consequence of his continued attempts to escape- he was chained in his ward at night- notwithstanding this + a burkundaz on duty- this morning he was found to have again escaped. A rope ladder, evidently let down by some accomplice, was found suspended from the roof. he had escaped under the projecting eaves + dropped down outside. Has not been retaken. Absconded.[72]

This former soldier was obviously determined not to be locked up by the British authorities, and despite recapture and the considerable obstacles presented by the asylum to his attempts to escape it appears that he finally managed it and successfully evaded recapture. Indeed, what is most significant about this example is that there appears to be members of the Indian community outside of the walls involved in facilitating his breakout. It seems then that the flight of individuals from the asylum can in certain cases be seen not just as examples of inmates resisting the colonial decision about their fate but also Indian families and community members resisting those decisions.

An inmate of the Jubbulpore asylum mentioned in the end of year report of 1880 seemed similarly determined to resist the British authorities.

> The criminal Mahso as a boy was confined in the Nagpur Jail reformatory wards for murder of a child in the Raipur District; whilst in jail he murdered another juvenile prisoner by driving the end of a pickaxe into the boy's back. For this second murder he was tried and acquitted on the ground of insanity in July 1876. During the whole time that he has been under observation

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[71] *Asylums in the Central Provinces for the Year 1879*, p2.
[72] Case Book IA, patient no.75, admitted 7 January 1861.

> in the asylum he has shown no signs of insanity beyond assaulting a child of one of the keepers, if that can be so considered; but he has escaped twice, and was caught in an attempt to get through the roof of his cell immediately after his admission.
>
> He has become a powerful and morose young man, determined to escape, or to commit another murder, which he believes would be followed by his execution. He does not hesitate to say that he would prefer being hung to remaining in the asylum without hope of escape...[73]

If the sentiments of Mahso were being accurately reported here then this is another example of a single-minded determination to resist the designs of the British authorities, where escape is the preferred option for the inmate but violence is openly considered as a legitimate means of taking on colonial institutionalisation.

Violence as a means of resisting the regimes of the asylums could take many forms. The most direct would be an assault on the superintendent himself, the head of the asylum and the symbol of British authority and control. Dr. Crombie at Dacca recounted an episode when "I was myself the subject of an attack by a lunatic who was sitting quietly weeding in the garden when, without warning, he suddenly sprang to his feet and seized a koodali, and rushed at me with the intention of felling me, but was luckily frustrated".[74] The resolution to do the British officer damage is clearly demonstrated in another instance in the tenacity of the assault on the superintendent at Patna:

> As I am writing cases, a small, well made man, habitually courteous, and a good weaver, comes up to me, makes an obeisance, says he is quite well and solicits his discharge. Before I can reply, he seizes the pen I have just laid down, that is taken from him, and he makes a dash at my walking stick, and is at once seized by a keeper. That quiet, civil and apparently harmless little man is now a veritable demon; with eyes starting with rage he tries to seize me, and failing covers me with most violent abuse, and continues to do so as he is being carried off to his cell.[75]

If this account is to be believed then it seems that the Indian inmate is singling out the British medical officer as the target of his anger and abuse even when restrained by the Indian staff.[76] The fact that it is the colonial representative that is made the focus of the patient's outburst of anger makes this a potent demonstration of resistance to colonial

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[73]*Asylums in the Central Provinces for the Year 1880*, p2.
[74]*Asylums in Bengal for the Year 1878*, p7.
[75]IGH Lower Provinces to Gvt.Bengal 27 July 1868 288, in GOI (Public) Procs December 19 1868, 30A.
[76]It is safe to assume that the staff member was Indian as European staff exclusively occupy the posts of Deputy Superintendent, Overseer or Matron in the records.

authority, especially as the attack is initially directed at the superintendent's pen which was often perceived as a potent symbol of power.[77]

There are instances where anger and resentment at decisions made by the colonial officers has occasioned violence which was directed at the Indian members of staff as representatives of the colonial order.

> I regret also to record a disastrous out break, attended with loss of life and severe injuries to several of the attendants took place in the Asylum on the 24th of March. An inmate of the Asylum named Keetapai, a non-criminal lunatic who had been under treatment for the past five years ... I had permitted this man to keep a dog; unfortunately a litter of pups were born, and on their growing up they became such a nuisance that I was obliged to order their being disposed of; this was an offence not to be forgiven, And after evidently brooding over it he persuaded a lunatic named Guggur Sing [sic] to join him in attacking the keepers. Keetapai was heard to say 'oh, we are lunatics, we can do what we like and kill them all and nothing will be done to us' ... they simultaneously attacked the warder of the criminal gate, knocked him down and rushed into the garden, attacking every keeper who attempted to oppose them ... the first keeper they met was killed near the entrance of the criminal ward by a fearful blow to the head, they then rushed towards the outer gate when they were met by another burkandaz who they also killed. On hearing the disturbance, Mr. Wilson the Deputy Superintendent, who was in his house, rushed into the Asylum to see what was the matter; they met him at the gate and he received some severe blows on the head, but was eventually rescued by the servants and one of the lunatics.[78]

It appears in this example that the decision of the British medical officer resulted in a revenge attack directed not solely at the individual who made the decision but at all his representatives in the asylum, be they Indian or European. The power of the colonial officer to order the lives and the spaces inside the asylum was explicitly contested here by an assault on those who were seen to be obeying his commands and imposing his orders.

Indeed the victim of violent action aimed at resisting the designs of the asylum regime was not always a representative of that regime. Surgeon-Major Niven at Colaba reported in 1874 that "one of the cases, a Parsee, admitted as a private patient under Section VII, resisted with such determination that when the beef-tea was administered by means of the stomach pump, as soon as the tube was withdrawn, he ejected the whole contents of the stomach".[79] The subject of the violence involved in resisting colonial designs here was the Indian himself.

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[77]See A.Skaria, 'Writing, Orality and Power in the Dangs, Western India, 1800s-1920' in *Subaltern Studies IX* (Oxford University Press 1997).

[78]*Annual Report of the Lahore Lunatic Asylum for the Year 1868*, p4.

[79]*Asylums in the Bombay Presidency for the Year 1873-4*, p3.

Another intriguing example in which it appears that the patient's own body is a site where the colonial regime was resisted crops up at the Nagpur asylum in a set of correspondence from 1875. The matter dealt with was "the subject of a female lunatic who had been for several years in the asylum having been delivered of a child".[80] That the female portion of the asylum population was routinely segregated from the male in the colonial asylums was mentioned earlier, and such certainly seems to have been the case at Nagpur where "the female lunatics are and have been from the first opening of the asylum lodged, as stated in my report written on the 19th of June 1868 ... in a separate building with walled airing ground distant about 100 yards from the male wards".[81] Nevertheless the woman had conceived while an inmate of the asylum. However this came to pass this is certainly an example of someone at the asylum resisting colonial discipline, as the correct distance to be preserved by men and women had obviously been ignored. The '100 yards' was more tnan a piece of ground; it was a cultural barrier between the sexes prescribed by colonial power. The child that was the result of a liaison in the asylum was a physical symbol of resistance to colonial authority as such offspring were unimaginable in the colonial design for correct relations between the sexes inside the asylum. Indeed there is the tantalising suggestion in the evidence that the woman herself was the one who had crossed that '100 yards'.

> In the new male ward, in the very furthest room i.e. furthest from the door, I found a young woman lying on the ground and two men lying near her. They were the only persons in this ward at the time.[82]

This statement appears in the report of the Commissioner of Nagpur who had arrived at the asylum to perform an inspection by chance in October 1873. It was later confirmed that "he found a woman and two men lying asleep in one of the male wards".[83] It was this woman who was found to be pregnant the following year in December. Obviously she did not conceive on this occasion but such testimony which fails to present signs of struggle and violence, problematic as it is because it is part of a set of correspondence where officers sought to defend and ruin careers, raises the possibility that her pregnancy was not the result of rape but rather it was she who had decided to transgress the boundary prescribed by the British between the females and the males. Whatever the truth about the child's conception, that conception and that

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[80]Gvt.C.Provs to Dr. Beatson 23 February 1875, 675-31 in GOI (Medical) Procs November 1875, 16A.
[81]Dr. Beatson to Gvt.C.Provs 23 February 1875, 12 in GOI (Medical) Procs November 1875, 20A.
[82]Minute by W.B.Jones 25 October 1873 in GOI (Medical) Procs November 1875, 16A.
[83]Dr. Beatson to Gvt.C.Provs 23 February 1875, 12 in GOI (Medical) Procs November 1875, 20A.

child are vivid demonstrations that even in the midst of a colonial institution the power of the British to control and order Indian lives was contested.

Perhaps the most dramatic evidence of resistance strategies involving the body of the individual resisting is in patient suicides. The summary of one such case reads: "One lunatic in that asylum committed suicide by hanging, after having failed in persevering attempts to starve himself to death".[84] It transpires in the superintendent's more detailed account that the reason the inmate had failed to starve himself to death was because "he had been fed regularly with the stomach pump".[85] Again, there are dangers with materials like this in assuming that the intentions ascribed to Indians were anything more than the guesses of the authors of the reports, but if the individual in question had embarked on a period of self-starvation in order to die and the asylum had responded by taking control of that individual's body in order to keep him alive, then the man's decision to take more immediate action to achieve the state he desired seems to be an instance of self-destruction as direct resistance to colonial objectives.

Such records of asylum violence though do offer reminders that not every incident in a colonised country needs contextualizing as a colonial encounter to explain it. It is perhaps a unique feature of the asylum records that the medical officer's desire to explain behavioural patterns in inmates meant that details of their behaviour before they became the focus of the attention of the colonial authorities are often available. For this reason there is information available with which it is possible to speculate about incidents, which while obviously happening in the confines of a colonial institution, do not necessarily need the colonial context to make them intelligible. Consider the passage from the Hyderabad superintendent's report:

> Restraint has rarely been needed, though we have several very dangerous lunatics in the asylum. One, subject to epileptic fits, murdered a Bunnia who had insulted him some days previously. For some time the people of the village had dreaded this man, who is very powerful. One day, since he has been in the asylum, he struck down a warder who annoyed him, and unless assistance had been at hand, would have killed him.[86]

While the account is obviously difficult to use for reasons associated with doubts about the origins of the various key pieces of information contained within it, it still raises the possibility that what appears as an act of resistance to the colonial order, the attack of a patient on a warder, might not have been a clash which needs the colonial

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[84] *Asylums in the Bombay Presidency for the Year 1877*, p52.
[85] Ibid., p11.
[86] *Asylums in the Bombay Presidency for the Year 1876*, p26.

relationship in the picture in order to explain it. Of course, in one sense the attack is an act of resistance to the colonial asylum regime, as anything which acted to disrupt or frustrate the aim of the medical officers to have a quiet and orderly institution is necessarily so. The possibility is though, that this could just be an example of a bad tempered man, with a history of reacting violently to abuse, simply doing that, reacting violently to abuse.

Consider also the report of a suicide by Dr. Wise at Dacca for 1873:

> The death by drowning was a very sad one. Sunia, the wife of one of the keepers, a Hindustani Chetin, was sent to the asylum on the 22nd July with a child five months old, as she had attempted to drown herself in the river. She was dull and melancholic and complained of abdominal pains and giddiness. The expulsion of fourteen lumbrici relieved her of these symptoms. Her affection for her child was most tender. She gradually became more cheerful and of her own accord did a little work. Regret was often expressed that she had tried to commit suicide. On the 18th August, after nursing her child, she went to the well, which is secured with a wooden lid, but in which is an opening 22 inches by 17 through which water is raised. Another lunatic was beside her. Before she could be stopped she had squeezed herself through this opening and before the lid could be removed, she was drowned.[87]

A suicide in a carceral institution is easily construed as an act of resistance as it represents the ultimate form of escape when other means of liberation are denied. However the history included in this case suggests that simply because a decision is made in the colonial context it is not to be assumed that that context is the correct one in which to understand that decision. The woman's decision to kill herself might be seen in hindsight as an act of resistance to the colonial regime as any act which denies that regime the power to decide an individual's fate is contesting the rights claimed by that regime. Yet a reading sympathetic to the woman in the superintendent's account would have it that it was the personal pain that haunted her long before she was incarcerated in the asylum which drove her to repeatedly attempt self-destruction. It just so happened that she was a colonial subject at the time she finally succeeded in taking her own life.

While all those Indians in the asylum were subjects of colonial power, most had ended up there as a result of the operations of the colonial state and were fed, cleaned, and treated according to colonial instructions, it must not be assumed that all of their decisions can be related back to that position of subjection. Some allowance should be made for the fact that in many instances even those Indians confined in that most colonial of contexts, the carceral institution, could make decisions about their own

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[87] *Asylums in Bengal for the Year 1873*, p38.

interaction with the world without regard for their position as subjects of colonial power.

The asylum environment may even have offered a protected space where there was scope for finding new roles and building new relationships. The following account comes from the case note of Neroo.

> This boy is a speechless, slavering idiot. Can scarcely give intimation to be led away to answer the calls of nature. Makes a kind of whining noise when angry. Suffered once from fever and dysentery. General health now fairly good, altho' limbs are weak. He has a frequent rocking motion but pays no attention to what passes around him. He was brought from the Almshouse. No history or trace of parents or relations.
>
> There is no change whatever in this boy except that he has attached himself to one of the lunatic inmates who has taught him to feed himself. General health good.[88]

It would seem that quite independent of the asylum regime and the staff of the institution the boy's levels of interaction with the world had increased and he had developed skills which he had given little evidence of ever having possessed before. This was due to a friendship that had developed between inmates in this colonial space apparently without the intervention or encouragement of anyone but the individuals involved. Of interest for similar reasons is an example from an earlier chapter, that of Phoola who "took a great fancy to a newly born infant whose mother a lunatic, would not look at it. Kept it continually on her knee + finally put it to her own breast, whence in three or four days milk actually flowed".[89] As was discussed earlier the reasons for this information being included on a case note are tied up in the power relations of the medical and colonial gaze but if the fact that a woman has decided to nurture an unwanted child is believed then this could be an interesting instance of an Indian setting out to satisfy her own desires and act according to her perceptions and agendas notwithstanding the colonial setting of the asylum and its regimen.

While these people were building new relationships others found themselves new roles in life within the asylum which gave them some satisfaction. Of one inmate it was said, "he may be said to have a kind disposition, as evinced in his attention to the sick- and his great boast was that he had cured some of the patients after they had been given up by the Native Doctor and myself".[90] Curiously the superintendent makes no attempt to rebut the boast so there remains the image of a patient carving out a function

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[88]Case Book IA, patient no.2, admitted 14 November 1859.
[89]Case Book IA, patient no.81, admitted 1 February 1861.
[90]*Lahore Lunatic Asylum for the Year 1868*, p4.

for himself in the asylum as a carer for the weak and the ill given up as a lost cause by the institution.

Indeed it should be pointed out that some inmates actively endorsed the regime of the colonial institution. "There are several who would not leave the Asylum even if permitted to do so and during the past year three of the discharged insanes have come back begging to be re-admitted. One of the three walked forty miles from the Civil Station of Barh. As might be expected, such men are somewhat silly, and they miss the kind care and attention to their wants when they go to their houses",[91] noted the superintendent at Dullunda. In a similar vein the medical officer at Poona related the fact that in 1876

> the re-admission was a native of Hindustan upwards of a thousand miles from the asylum. He had been discharged in the early part of the year, his brother having come to take him home; he had money of his own. After some months not being happy he left without telling any of his friends, with only a few rupees in his pockets and came back to the asylum, asking to be re-admitted.[92]

It would seem that as part of their personal survival strategies these patients were opting for the asylum regime over a struggle with life in the environment outside of the carceral walls.

Perhaps most important of all it must be remembered that the majority of those admitted to the colonial asylum did not get pregnant, did not murder or attack anyone and did not even bother to hurl a word or two of abuse. More typical than the patients who acted in such ways, or indeed actively sought to carve out roles or relationships in the asylum or to secure a permanent berth there are those whose case notes read like that of Sunkura:

> Sunkura alias Hungra. M. Dementia. Mussul. beggar. 25. 21 Novr. 1861
>
> Admitted from the Lucknow Havalabee. He was obstreperous + very incoherent in his speech on admission. For several months little improvement has appeared, but for the last 2 months he has been quiet + well conducted and has worked steadily in the garden. He is now sufficiently well to be discharged.[93]

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[91] *Asylums in Bengal for the Year 1863*, p29.
[92] *Asylums in the Bombay Presidency for the Year 1876*, p26.
[93] Case Book IA, patient no.152, admitted 21 November 1861.

Far from resisting the asylum regime Sunkura calms down after a period of upset or anger and sets about doing what is expected of him as a patient in a mental institution. He gives noone any trouble, does his work and secures his release.

CONCLUSION.

As was suggested in an earlier chapter the asylum was an alien place in Indian society and was in every way implicated in the power relations of colonialism. The people who found themselves inmates of the institution were, with significant exceptions, incarcerated because the colonial authorities viewed them as potential sources of disruption. The regime designed for them once incarcerated envisioned treating their bodies and their minds so that they became models of utility for the colonial design, as ordered, self-regulating and productive individuals. Colonial power put them in the asylum and would transform them.

Their responses to being placed in this most colonial of milieus are extremely important then as "resistance even at its most ambiguous ... highlights the presence and play of power in most forms of relationship and activity".[94] Indeed, the responses of individuals isolated in these institutions seems to be just the place to examine the actions and reactions of colonial subjects as these are just the sort of place to which the contemporary historian is being directed in search of resistances, Rosalind O'Hanlon for one urging that "we should look for resistances of a different kind: dispersed in fields we do not conventionally associate with the political".[95]

What is apparent then is that in the asylum there are many acts of resistance but acts of the kind that James Scott has described as, "individual and often anonymous".[96] In one sense many of the acts described have been acts of resistance to the colonial order of the asylum be they intended as such or not. The decision to attack the European superintendent of the asylum may be seen as a moment when colonial authority was overtly contested as might the decision to refuse to do more than the bare minimum at work or to carry out the full range of duties expected by the colonial authority. Yet the decision to have sexual intercourse in the ward of the opposite sex, or the urge to

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[94]S.Ortner, 'Resistance and the Problem of Ethnographic Refusal', in *Comparative Study of Society and History* 1995, p175.
[95]R.O'Hanlon, 'Recovering the Subject', p223.
[96]J.Scott, *Weapons of the Weak: everyday forms of peasant resistance*, (Yale University Press1985), p297.

commit suicide while an inmate, may also be seen as acts of resistance to colonial power simply because they acted to upset specifically designed colonial orders.

It is just as important to remember that not all responses to colonial power can be characterised as resistance. Often Indians worked hard to make the regimes of colonialism work although here it must be remembered that they did so not because they were subjected by colonial power but because they had their own agendas to pursue in which the opportunities presented by colonialism were welcomed as the means to an end.

Perhaps most significant of all though is the fact that it appears that not all actions in the colonial context, even one as overtly colonial as a carceral institution, can be related to that context and this raises the important possibility that colonial power is often shaded into accounts of Indian actions in the nineteenth century on the assumption that it was significant rather than on the evidence that it was so. This will be more fully discussed in the conclusion.

CONCLUSION.

CONCLUSION.

> All these folk are saying, "It was plague. We've had the plague here". You'd almost think they expected to be given medals for it. But what does that mean- 'plague'? Just life, no more than that.[1]

The period 1857 to 1880 began with considerable ambitions for the lunatics of British India and ended in asylum closures and special investigations into the expense of providing such institutions. In 1862 there was an exchange of correspondence between the North-Western Provinces and the Government of India about a survey that the Inspector-General of Prisons had organised. After canvassing the District Officers of the area he estimated the total number of lunatics in the N.W.P.

> Dr. Clark's own conviction resulting from his own investigation is that there are 1250 cases to be provided for. Of this 328 can be sent to Bareilly and 328 to Benares so that there are still 600 candidates for admission to the proposed asylum.[2]

His plans were to house *all* those considered 'lunatic' by the British in institutions to be provided for the purpose, even the "957 ... said to be taken care of by their friends, a circumstance which I think very doubtful at least, the amount of care bestowed upon them must, I fear, be very small indeed".[3]

By the end of the 1870s such ambitions would have been unthinkable. Typical of the period was the Bengal Medical Expenditure (O'Kinealy) Committee of 1878/9[4] which devoted a whole separate section of its report to the lunatic asylums of the area. The differing costs of the patients in each asylum, the diverse dieting arrangements and associated expenditure and the varying commitment of each superintendent to profitable manufacturing were all investigated as the cost of providing such facilities began to be felt as a burden. With the closure of the Moydapore asylum in 1877 and the Hazaribagh asylum in 1879 the last years of the 1870s signalled an end to the burst of energy which had more than doubled in two decades the number of asylums that the British had managed to get up and running by 1858.

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[1] A.Camus (translated by S.Gilbert), *The Plague*, (Penguin 1960), p250.
[2] Gvt.NWP to GOI 2155A of 1862 in GOI (Public) 20 October 1862, 26A.
[3] IGP to Gvt.NWP 30 June 1862 in GOI (Public) 20 October 1862, 27A.
[4] *Report on the Lunatic Asylums in Bengal by the Committee appointed to inquire into medical expenditure in Bengal.*

An investigation of this burst of energy has implications for a number of current debates about colonialism. Ranajit Guha and Shahid Amin[5] have both shown how the documents of the colonial period are no mere reports of events but are rather fictions produced within colonial discourses of domination and legitimation. Documents like the case note at the asylum in British India have similarly been found to have been formed within colonial discourse, although tracing the discursive elements in the case notes provides an important reminder. The reason the case note exists is because a British officer is sat in an institution established by fellow Europeans, who had the control and disciplining of a subject population in mind when they set it up, writing about Indians that had been brought to him to incarcerate. Even in this most colonial of encounters, however, colonial discourses and power relations should not be privileged as the context for understanding the documents produced. It is not simply the fantasies of Empire through which the medical officers at the asylums imagined the people presented to them and which formed the discursive circumstances in which the case notes were created. The discourses of nineteenth century Western medicine, ideas about gender and the prejudices of men schooled in political economy are all implied in the case notes.

Whilst a discussion of the discursive circumstances in which documents were formed in the colonial asylum is important to show how power relations shaped knowledge, discourse and documents can only ever be the starting point for exploring colonialism. Thomas Richards misses the connection between knowledge and power when he concludes of British colonial officials that, "they often could do little other than collect and collate information, for any exact civil control, of the kind possible in England, was out of the question".[6] For colonial officials, information was the key to civil control, as mapping out what they imagined were the problem populations in the societies to be controlled was the first step to be taken in dealing with them.

Colonial officials fretted that they had such limited access to the Indian population through which to gather information:

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[5]R.Guha (ed.), 'The Prose of Counter-Insurgency', in R.Guha, *Subaltern Studies II* (Oxford University Press 1983); S.Amin, 'Approver's Testimony, Judicial Discourse: The case of Chauri Chaura', in R.Guha (ed.), *Subaltern Studies V* (Oxford University Press 1987).
[6]T.Richards, *The Imperial Archive: knowledge and the fantasy of Empire*, (Verso London 1993), p3.

> Until some... network of enquiry is skilfully spread abroad the country we shall never be in a position to judge what is naturally going on in the inner life and domestic concerns of the teeming population of India.[7]

For this reason the points of access that they did have, such as the asylum in which a rare opportunity arose to observe a captive population of Indians, assumed great importance and information produced there quickly entered the wider colonial system through the writing of reports and the compilation of statistics. Knowledge was very much 'produced' at the asylum, as local agendas and larger colonial and governmental anxieties met in the institution and formed the context in which the asylum population was observed. When looking at the inmates of the asylum the medical officers imagined the presence of types and human categories and recorded this. The meta-language of statistics and the information gathering systems of colonialism meant that the way the asylum superintendent saw his patients quickly became the way colonial government saw the Indian population as a whole. Indeed investigating these imagined human types, this 'produced' knowledge, is not just an arid exercise in tracing the archaeology of colonial categories or the information network of a colonial regime. Such an investigation leads directly to the colonial experience as power was exercised on the basis of the knowledge produced at the asylum. Men were incarcerated and customs and habits demonised and criminalized by the colonial regime because of the way the superintendent saw his patients and the way the colonial system was geared to collate and disseminate his observations.

Indeed, the asylum was fully implicated in the power relations of colonialism as it operated in tandem with larger colonial projects to drill or discipline the Indian population, by removing the troublesome and the unproductive to leave only the ordered and the efficient. The asylum regime also acted on the micro-level as it was designed to discipline those individuals removed from Indian society, to act upon their bodies and minds so that ordered and productive individuals were created from what the British perceived as the jumbled and chaotic Indian. In the asylum medical power, so important in the disciplinary projects of modern government as it was emerging in Europe in the nineteenth century, converged with the colonial power which the British exercised in incarcerating Indians in their institutions. But it is important to note that this convergence of the medical and the colonial was not axiomatic, and that there are examples from cases involving lunatics in which medical power and colonial power

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[7]Super.Police Pahlunpore to Gvt.Bombay 15 February 1868 in GOI (Judicial) 19 February 1870, 21-35A.

operated in conflict. The following is an account of the case of Abdulla, a convict at Port Blair.

> After his arrival he refused altogether to work and he was impertinent and excited when spoken to. I therefore sent him before the 3rd medical officer for examination and opinion as to mental condition. That officer replied that in his opinion the man was suffering from mental aberration. I then wrote to the officer in charge Northern District recommending the man for transfer to the Haddo Lunatic Asylum and pointing out that the Jail was not a proper place for a man in his condition.
>
> Before submission of the recommendation to the Chief Commissioner the matter was referred to the senior medical officer who examined the man and stated that in his opinion the convict was only feigning madness.
>
> A copy of his memo being sent to me, I then sentenced the man to six stripes with a rattan. The 3rd medical officer, however, being of opinion that he is insane declines to pass him for that punishment.[8]

Colonial power is disciplinary in this example and it acts to punish the man's body in order to manage his behaviour. However the power of the medical judgement as an estimation of human competence acts to frustrate the disciplinary designs of colonial power. The senior medical officer eventually concurs with the opinion of his lesser colleague and the convict was sent to the asylum untouched by the colonial rattan.

This idea, that within the colonial context there are 'power(s)' rather than just 'power' is crucial in understanding the asylum, and indeed the colonial, experience. In the above example it was the power of Western medicine which contests the power of colonialism, but there have been other types of power operating in many of the examples included in these pages. The importance of the Indians in and around the asylum and the power that they wielded must be emphasised.

Both chapters in which the responses of Indians around and inside the asylum were considered showed that Indians acted in ways which shaped the colonial encounter. Such observations are important as rejoinders to those who still have a somewhat Fanonian vision of the colonial encounter where, "this encounter was framed by and riddled in the fundamental fact about both colonialism and Orientalism: domination".[9] The colonisers did not dominate but desired to dominate and the instances where their

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[8]Officer Southern District to Officer Northern District 21 January 1879 in GOI (Port Blair) May 1879, 42-43B: the 'asylum' at Haddo was in fact no such thing as understood by the standards of the day. Correspondence in 1876 (Home (Port Blair) November 1876, 4-7A) established that there was simply a separate shed at Haddo in which all the convicts 'who will submit to no discipline' were sent to separate them out from the other prisoners.

[9]N.Dirks, 'Introduction: Colonialism and Culture' in N.Dirks (ed.), *Colonialism and Culture*, (Ann Arbor 1992), p23.

projects were disrupted and contested emphasise that their domination remained fantasy rather than 'fact' and remained well short of 'hegemonic'.

They are also important as rejoinders to those who have rather Foucauldian visions of asylums and other medical institutions. Michel Foucault's vision of such institutions and their regimes tended to be expressed in very absolute terms. As has already been stated, for Foucault the asylum was:

> A religious domain without religion, a domain of pure morality, of ethical uniformity ... an instrument of moral uniformity and of social denunciation.[10]

The frustration of the asylum regime by the Indian staff and the resistance offered by the patients shows that while the asylum may have been established and intended as an instrument of 'moral uniformity', in reality it rarely functioned as such. The patients who seem to be acting without regard to their environment are perhaps the most interesting here, as those who sneak off for sex or who form friendships with other patients show that within the asylum there was in practice considerable space for pursuing agendas arrived at independently of the designs of the asylum.

It is important to remember that in key respects many such moments of resistance to colonial and institutional power were no such thing. The decision to assault, have sex or self-immolate was often taken without regard to the colonial or institutional context. They may well have resulted in the frustration of the colonial and medical power but they were never intended to. They may well have been intended as acts of resistance, but not resistance to colonial or medical power. The woman's suicide after the birth of her child could be placed in the context of contesting patriarchal culture, while the man's violent reactions to insult might just as easily be placed in the context of local standards of status and honour. Whatever is correct, the evidence certainly suggests that these individuals were often pursuing agendas which were arrived at before they became inmates of the asylum and subjects of colonial and medical power.

In this sense then Nicholas Thomas is correct to point out that the habitual relating of the actions of indigenous peoples to the colonial context just because they occur in that context "excludes the possibility that 'natives' often had relatively autonomous representations and agendas that might have been deaf to the enunciations of

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[10]Michel Foucault (translated by Richard Howard), *Madness and Civilization: A History of Insanity in the Age of Reason*, (Routledge London 1989), pp257-259.

colonialism".[11] As such, resistance and compliance come to resemble one another to the point that a distinction is no longer necessary, in as much as both deny domination by colonial power but both recognise the power of other agendas, other powers even, to that of colonialism. Those in the asylum who were cooperating with the colonial order, the attendants who made the asylum tick or the patients who carved out roles in the institution which guaranteed its smooth running were doing so on the same basis as those whose actions frustrated and disrupted colonial means and ends. That is, they were not doing the bidding of the coloniser because they were purely subjects of colonial power, but because the opportunity presented by the colonial system for employment, security, enrichment etc. provided a way for them to pursue or realise agendas which may have been determined, and were no doubt in the process of being transformed and determined at the moment of decision, by reference to a range of cultural systems, including the colonial, the religious, the patriarchal etc.

Indeed, even those examples given above where the action of an individual seems directly linked to the colonial presence, and that colonial presence seems to be the essential factor in the decision to act in that way, cannot be assumed to be as they appear. Although much of the work in this project has sought to deconstruct the 'lunatic' status of those deemed so by the British, the possibility that some of those so called did experience mental states which would be popularly called 'madness' raises infinite and intriguing possibilities. The fact that certain individuals imagined themselves kings, deities or even vegetables when they appear not to have been makes their agendas an extremely difficult subject upon which to speculate. Yes, these people would have had agendas, but not ones which were related to anything that a good social scientist would be able to discover such as gender, social status, position in the colonial hierarchy etc. In other words these people remind us that there is the possibility of highly individualised decision making which may have very little to do with those aspects of the universe that a historian or sociologist would be able to pick out of a historical document.

This is not to resurrect the figure of Western humanism which Rosalind O'Hanlon has called, "the self-originating, self-determining individual, who is at once a subject in his possession of a sovereign consciousness whose defining quality is reason and an agent in his power of freedom".[12] Rather it is to emphasise a point that she makes

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[11]N.Thomas, *Colonialism's Culture: anthropology, travel and government*, (Polity Press Cambridge 1994), p57.

[12]R.O'Hanlon, 'Recovering the Subject: Subaltern Studies and histories of resistance in colonial South Asia', in *Modern Asian Studies* 22, 1, 1988, p191.

elsewhere that, "power takes effect: as a play of forces which continually moves across and bursts through our efforts to establish coherent fields of activity".[13] If she had said 'power(s)' she would have been more accurate, as in this work on various aspects of the asylum the individuals that have been discussed have been the subjects, and their actions the effects of colonial power, patriarchal power, the power of capitalism, the power of oral history, the power of the gene, the power of religious perceptions, the power of status prescriptions, matriarchal power, the power of legal tradition, the power of local landlords, the power of the hormone, and so on.

Power is everywhere and sometimes the historian or the social scientist attempts to name it, as colonial power or patriarchal power etc. Yet it is just power, and attaching too much significance to naming it at any one moment obscures this fact. Colonial power in this project is not really colonial power, like the plague in the Camus novel it is just power. And this is, after all, 'just life, no more than that'.

[13]R.O'Hanlon, 'Recovering the Subject', p216.

APPENDIX I.

Asylums operating in the period 1857-1880.

APPENDIX I. ASYLUMS OPERATING IN THE PERIOD 1857-1880.

These institutions are arranged by administration and by alphabetical order. The date in the bracket is included if the asylum has been positively identified as founded in this period.

ASSAM.	Tezpore (1876).
BENGAL.	Berhampore (1874). Cuttack (1864). Dullunda. Dacca. Hazaribagh (1876). Moydapore. Patna.
BOMBAY.	Ahmedabad (1862). Colaba. Dharwar. Hyderabad (c. 1871). Poona (1867).
BURMA.	Rangoon (1870).
CENTRAL PROVINCES.	Jubbulpore (c. 1867). Nagpur (1864).*
HYDERABAD ASSIGNED DISTRICTS.	Amraoti (1877).
MADRAS.	Calicut. Madras. Vizagapatam (1863).*
NORTH-WESTERN PROVINCES.	Agra (1869). Bareilly (1862).* Benares.

OUDH.	Lucknow (1859).
PUNJAB.	Delhi (1867).
	Lahore.

Unless otherwise stated the date for the opening of the asylum was found in the records of the period.

*Date available in S.Sharma, *Mental Hospitals in India*, (Directorate General of Health Services New Delhi 1990).

APPENDIX II.

Act No. XXXVI of 1858.

APPENDIX II: ACT NO.XXXVI OF1858.[1]

ACT NO. XXXVI. OF 1858.

[*Received the assent of the G. G. on the 14th Sept.*, 1858.

1, 2, 3. Presidency Governments may establish Lunatic Asylums; which (2) shall be managed according to rules, and have visitors; (3) who shall visit and report periodically.

4. Darogahs to apprehend reputed Lunatics, and bring them before Magistrate, who may commit to Asylum, unless a friend will be responsible for him.

5, 6. Magistrate may enquire into treatment of Lunatics generally, and make order for their proper treatment; and (6) these powers in Presidency towns to be exercised by Commissioner of Police, &c.

7, 8. No person to be received into a Lunatic Asylum in Presidency Town, &c., without order in specified form, unless previously found or certified to be Lunatic, &c. Friends of Lunatic, to engage for expenses; or (8) out of Presidency Town without order of Civil Court, &c., in what way application for admission shall be made.

9, 10. Visitors of Asylum may order discharge of Lunatic; and (10) discharge may be ordered on application of relative and an undertaking for proper care of Lunatic.

11. Inspector of Gaols may order removal of Lunatic from one public Asylum to another.

12. Defective or incorrect medical certificate may be amended.

13. In case of escape from Asylum, Lunatic may be re-taken.

14. Government to pay the Asylum expenses in certain cases.

15, 16. Civil Court may order expenses to be paid out of Lunatic's estate, if he has any; (16) without prejudice to obligation of relative to maintain Lunatic.

17. Saves powers of Supreme Courts under Act XXXIV., 1858, and under Act IV., 1849.

18. Interprets the words "Lunatic," &c.

Schedule of Forms and Statement.

An Act relating to Lunatic Asylums.

Whereas it is expedient to provide for the reception and detention of Lunatics in Asylums, established for that purpose, it is enacted as follows:

Preamble.

I. The Executive Government of any Presidency or place, with the sanction of the Governor General of India in Council, may establish Asylums for the reception and detention of Lunatics at such places within the limits of the said Government as may be deemed proper. Any such Executive Government may also, if it think fit, grant licenses to any private persons for the establishment of such Asylums within the said limits, and may withdraw such licenses.

Lunatic Asylums may be established by Government or may be licensed.

II. The management of every Lunatic Asylum and the care and custody of its inmates shall be regulated according to such rules as shall from time to time be sanctioned by the Executive Government. The Executive Government shall ap-

Rules for the management of Asylums to be sanctioned by Government.

Appointment of visitors.

[1]From W.Theobald, *The Legislative Acts of the Governor-General of India in Council*, volume II, pp862-872.

point for every Asylum not less than three visitors, one of whom at least shall be a Medical Officer. The Inspector of Gaols (where such office exists) shall be a visitor *ex-officio* of all the Asylums within the circle of his inspection.

Monthly inspection by visitors.

III. Two or more of the visitors, one of whom shall be a Medical Officer, shall, once at least in every month, together inspect every part of the Asylum or Asylums of which they are visitors, and see and examine, as far as circumstances will permit, every Lunatic therein, and the order and certificate for the admission of every Lunatic admitted since the last visitation of the visitors; and shall enter in a book to be kept for that purpose any remarks which they may deem proper in regard to the management and condition of the Asylum and the Lunatics therein.

Wandering and dangerous Lunatics to be sent to the Magistrate.

Certificate and order for reception in Asylum.

IV. It shall be the duty of every Darogah or District Police Officer to apprehend and send to the Magistrate all persons found wandering at large within his district who are deemed to be Lunatics, and all persons believed to be dangerous by reason of Lunacy. Whenever any such person as aforesaid is brought before a Magistrate, the Magistrate, with the assistance of a Medical Officer, shall examine such person, and if the Medical Officer shall sign a certificate in the Form A. in the Schedule to this Act, and the Magistrate shall be satisfied on personal examination or other proof that such person is a Lunatic and a proper person to be detained under care and treatment, he shall make an order for such Lunatic to be received into the Asylum established for the division in which the Magistrates jurisdiction is situate, or, if such Lunatic is not a native of the country and the circumstances of the case so require, into a Lunatic Asylum at the Presidency; and shall send the Lunatic in suitable custody to the Asylum mentioned in such order. Provided that, if any friend or relative of any Lunatic, who is believed to be dangerous, shall undertake in writing to the satisfaction of the Magistrate that such Lunatic shall be properly taken care of, and shall be prevented from doing injury to himself or others, the Magistrate, instead of sending him to an Asylum, may make him over to the care of such friend

In certain cases a Lunatic may be committed to the care of his friends or relatives.

Or sent to a licensed Asylum.

or relative. Provided also that if any such friend or relative shall desire that the Lunatic may be sent to a licensed Asylum instead of the public Asylum of the Division, and shall engage in writing to the satisfaction of the Magistrate to pay the expenses which may be incurred for the lodging, maintenance, medicine, clothing, and care of the Lunatic in such Asylum, the Magistrate may send the Lunatic to the licensed Asylum mentioned in the engagement.

In case of neglect or cruel treatment of a Lunatic, Magistrate may order relative, or person bound to maintain him, to provide for the proper treatment of such Lunatic.

V. If it shall appear to the Magistrate, on the report of a Police Officer or the information of any other person, that any person within the limits of his jurisdiction deemed to be a Lunatic is not under proper care and control, or is cruelly treated or neglected by any relative or other person having the charge of him, the Magistrate may send for the supposed Lunatic, and summon such relative or other person as has or ought to have the charge of him; and if such relative or other person be legally bound to maintain the supposed Lunatic, the Magistrate may make an order for such Lunatic being properly cared for and treated, and, if such relative or other person shall wilfully neglect to comply with the said order, may commit him to gaol for a period not exceeding one month. If there be no person legally bound to maintain the supposed Lunatic, or if the Magistrate think fit so to do, he may proceed as prescribed in the last preceding Section, and upon being satisfied in manner aforesaid that the person deemed to be a Lunatic is a Lunatic and a proper person to be detained under care and treatment, may make an order for his reception into such Asylum as aforesaid. It shall be the duty of every Darogah or District Police Officer to report to the Magistrate every such case of neglect or cruel treatment as aforesaid which may come to his knowledge.

If no person bound to maintain him, Magistrate may make an order for his reception in Asylum.

Darogah to report neglect.

Commissioner of Police, &c., to act in the Presidency Towns and Straits' Settlements.

VI. All acts which the Magistrate is authorized or required to do by the two last preceding Sections, may be done in the Presidency Towns and Stations of the Straits' Settlements by the Commissioner of Police; and all duties which a Darogah or

District Police Officer is authorized or required to perform, may be performed in any of the said Towns and Stations by an Officer of the Police Force not below the rank of Inspector.

Order and certificate for reception into an Asylum in Presidency Towns and Straits' Settlements.

VII. Except as otherwise hereinbefore provided, no person shall be received into a Lunatic Asylum in any Presidency Town, or in any Station of the Straits' Settlements without an order under the hand of some person in the Form B. in the Schedule to this Act, together with such statement of particulars as is contained in the said Form B.; nor unless such person has been found Lunatic by inquisition or under an enquiry directed by an order of one of the Courts of Judicature established by Royal Charter, without the medical certificate containing the particulars in Form A. in the Schedule to this Act, of two persons, each of whom shall be a Physician or Surgeon, and one of whom shall be a Presidency Surgeon or a Surgeon in the employment of the Government. When such order is presented, the visitors or manager of the Asylum, before admitting the Lunatic into the Asylum, may require the friends of the said Lunatic to engage to pay the expenses which may be incurred for the lodging, maintenance, clothing, medicine, and care of the Lunatic, unless it shall appear to the said visitors that they have not sufficient means of doing so.

In places other than Presidency Towns, &c., no person to be received into Asylum without order of Civil Court.

VIII. *Clause* 1.—In places other than those specified in the last preceding Section, no person shall be received into a Lunatic Asylum, except as otherwise hereinbefore provided, without an order of the Civil Court.

Application for order to be made by a guardian, if a guardian has been appointed.

Clause 2.—When any person has been adjudged to be a Lunatic, and a guardian for such Lunatic has been appointed by the Court of Wards or the Collector or by the Civil Court, if such guardian shall desire that the Lunatic be admitted into a Lunatic Asylum, he shall make application to the Civil Court, and the Judge, with the assistance of a Medical Officer, shall examine such Lunatic, and if the Medical Officer shall sign a certificate in the Form A. in the Schedule to this Act, and the Judge shall be satisfied that the Lunatic is a proper person to be detained under care and treatment in a Lunatic Asylum, he shall make an order for such person to be received into the Asylum

established for the Division in which his jurisdiction is situate, or, if he think fit, into any licensed Asylum mentioned in the application.

Application where no guardian has been appointed.

Clause 3.—If any relative or friend of any person for whom a guardian has not been appointed by the Court of Wards or the Collector or by the Civil Court, desires that such person may be admitted into a Lunatic Asylum, he may make application to the Civil Court, and the Judge, if he see sufficient reason for so doing, shall enquire into the fact of Lunacy in the same manner as if an application had been made to the Civil Court under the provisions of Section III. of Act XXXV. of 1858, entitled " An Act to make better provision for the care of the estates of Lunatics not subject to the jurisdiction of the Supreme Courts of Judicature," and if the Lunacy be established, the Judge may then proceed in the manner prescribed in the second Clause of this Section.

Order for payment of expenses.

Clause 4.—Whenever the Judge shall make an order for the reception of any person into a Lunatic Asylum, he shall, at the same time, make an order for the payment of the expenses to be incurred for the lodging, maintenance, clothing, medicine, and care of such person; and such expenses shall be recovered by the Judge on the application of the visitors or manager of such Asylum. Provided, however, that, if it shall appear to the satisfaction of the Judge that the Lunatic has not sufficient property, and that no person legally bound to maintain the said Lunatic has sufficient means for the payment of such expenses, he shall certify the same in the order for the reception of the Lunatic into the Asylum, instead of making such order for the payment of expenses as aforesaid.

Proviso.

Order of discharge from Asylum.

IX. It shall be lawful for three of the visitors of any Asylum of whom one shall be a Medical Officer, by writing under their hands, to order the discharge of any person detained in such Asylum. When such order is given, if the person is detained under the order of any public Officer, notice of the order of discharge shall be immediately communicated to such Officer.

X. When any relative or friend of a Lunatic detained in any Asylum under the provisions of Section IV., Section V., or Section VI., of this Act, is desirous that such Lunatic shall be delivered over to his care and custody, he shall make application to the Magistrate or Commissioner of Police under whose order the Lunatic is detained, and the Magistrate or Commissioner of Police, if he think fit, after communication with the visitors or with one of them being a Medical Officer, and upon the undertaking in writing of such relative or friend to the satisfaction of the said Magistrate or Commissioner that such Lunatic shall be properly taken care of, and shall be prevented from doing injury to himself or others shall make an order for the discharge of such Lunatic, and such Lunatic shall thereupon be discharged.

Order of discharge on undertaking of relative for due treatment of the Lunatic.

XI. The Inspector of Gaols may direct the removal of any Lunatic from any public Asylum to any other public Asylum within the circle of his inspection, and such order shall be sufficient authority for the removal of such Lunatic, and also for his reception into the Asylum to which he is ordered to be removed.

Inspector of Gaols may make order of removal from one public Asylum to another.

XII. If, after the reception of any Lunatic into any Asylum, it appear that the order or the medical certificate or certificates upon which he was received is or are defective or incorrect, the same may at any time afterwards be amended by the person or persons signing the same with the sanction of two or more of the visitors of the said Asylum, one of whom shall be a Medical Officer.

Amendment of order or certificate.

XIII. Every person received into a Lunatic Asylum under any such order as is required by this Act accompanied by the requisite medical certificate, may be detained therein until he be removed or discharged as authorized by this Act, and in case of escape may, by virtue of such order, be re-taken by the manager of such Asylum, or any Officer or servant belonging thereto, or any other person authorised in that behalf by the said manager, or any Police Officer, and conveyed to and received and detained in such Asylum.

Order and certificate to justify detention and re-capture after escape.

XIV. When any Lunatic is sent to a licensed Asylum by

In what cases Government to pay for the maintenance of Lunatic.

order of a Magistrate or a Commissioner of Police under Section IV., Section V., or Section VI. of this Act, and when a Lunatic is admitted into such Asylum under Section VII., or an order for the reception of a Lunatic is made under Section VIII., and no engagement has been taken from the friends of the Lunatic or order made by the Judge for the payment of expenses under the said Section VII. or Section VIII. respectively, the expense of the lodging, maintenance, clothing, medicine, and care of such Lunatic shall be paid by the Government to the manager of such Asylum.

Civil Court, on application of Magistrate, may make order for the payment of the cost of maintenance out of the Lunatic's estate, or by person bound to maintain him.

XV. The Magistrate or Commissioner of Police by whom any Lunatic has been sent to a Lunatic Asylum, if it appear to such Magistrate or Commissioner that such Lunatic has an estate applicable to his maintenance and more than sufficient to maintain his family, or that any person is legally bound to maintain and has the means of maintaining such Lunatic, may apply to the chief Civil Court of original jurisdiction within the local jurisdiction of which the estate of the Lunatic may be situate or the person legally bound to maintain him may reside, and such Court shall enquire into the matter in a summary way, and on being satisfied that such Lunatic has an estate applicable to his maintenance, or that any person is legally bound to maintain and has the means of maintaining such Lunatic, shall make an order for the recovery of the charges of the lodging, maintenance, clothing, medicine, and care of such Lunatic out of such estate or from such person. Such order shall be enforced in the same manner and shall be of the same force and effect and subject to the same appeal as any judgment or order made by the said Court in a regular suit in respect of the property or person therein mentioned. Any personal property which may be in the possession of a Lunatic found wandering at large may be sold by the Magistrate and the proceeds thereof (or such part of the same as may be necessary) applied towards the payment of the charges of the lodging and maintenance of the Lunatic, and of any other expenses incurred on his behalf.

Enforcement, &c., of order.

Property in the possession of a Lunatic found wandering.

XVI. The liability of any relative or person to maintain any Lunatic shall not be taken away or affected by any provision contained in this Act.

Saving of liability of relatives to maintain Lunatic.

XVII. Nothing contained in this Act shall be taken to interfere with the power of any of the Courts of Judicature established by Royal Charter over any person found to be Lunatic by inquisition or under the provisions of Act XXXIV., 1858, entitled "An Act to regulate proceedings in Lunacy in the Courts of Judicature established by Royal Charter," or with the rights of any Committee of the person or estate of such Lunatic, or to affect the provisions of Act IV. of 1849, entitled "An Act for the safe custody of Criminal Lunatics."

Saving of powers of Supreme Court, &c., and of Act IV. of 1849.

XVIII. The word "Lunatic," as used in this Act, shall mean and include every person of unsound mind, and every person being an idiot.

Interpretation. "Lunatic."

The word "Magistrate" shall include a person exercising the powers of a Magistrate.

"Magistrate."

SCHEDULE.

FORM A.

CERTIFICATE OF MEDICAL OFFICER.—(*See Sections IV. and VIII.*)

I, the undersigned (*here enter name and official designation*), hereby certify that I, on the day of at , personally examined (*here enter name and residence of Lunatic*), and that the said is a Lunatic (*or an idiot, or a person of unsound mind*), and a proper person to be taken charge of, and detained under care and treatment, and that I have formed this opinion on the following grounds, namely:—

1. Facts indicating insanity observed by myself (*here state the facts*).

2. Other facts (if any) indicating insanity communicated to me by others (*here state the information and from whom*).

(Signed) ————————

FORM B.

ORDER FOR THE RECEPTION OF A PRIVATE PATIENT.—(*See Section VII.*)

I, the undersigned, hereby request you to receive A. B., a Lunatic [*or an idiot, or a person of unsound mind*], as a patient into your asylum. Subjoined is a statement respecting the said A. B.

(Signed) Name.

Occupation (if any).

Place of abode.

Degree of relationship (if any), or other circumstance of connection with the patient.

Dated this day of One thousand eight hundred and

To , Superintendent of the Asylum at [*describing the Asylum*].

STATEMENT.

[*If any of the particulars in this Statement be not known, the fact to be so stated.*]

Name of patient, with Christian name at length.

Sex and age.

Married, single, or widowed.

Condition of life, and previous occupation (if any).

The religious persuasion, as far as known.

Previous place of abode.

Whether first attack.

Age (if known) on first attack.

When and where previously under care and treatment.

Duration of existing attack.

Supposed cause.

Whether subject to epilepsy.

Whether suicidal.

Whether dangerous to others.

Whether found Lunatic by inquisition or enquiry under order of Court, and date of Commission or order for inquisition or enquiry.

Whether any member of patient's family has been or is affected with insanity. (Signed) Name.

[*Where the person signing the Statement is not the person who signs the order, the following particulars concerning the person signing the Statement are to be added, namely:*]

Occupation (if any).

Place of abode.

Degree of relationship (if any), or other circumstances of connection with the patient.

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